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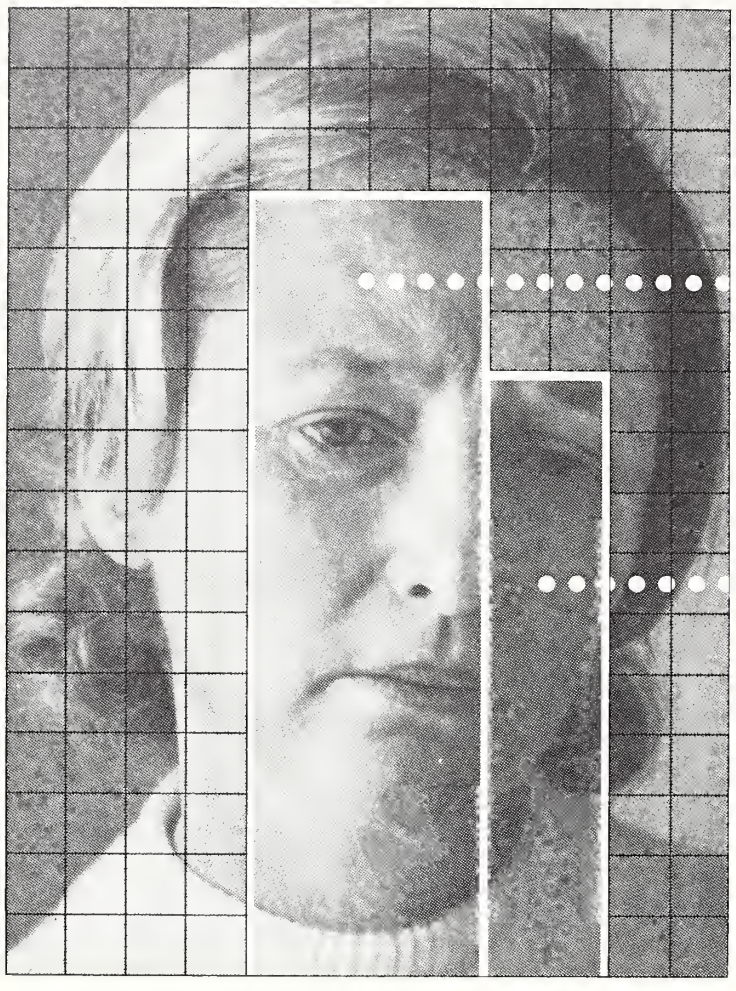
Oklahoma Legislature Reconvenes

The Assistant Attorney General's Report on Professional Liability in Oklahoma

An Interview with Governor David L. Boren

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Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under careful

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respond to one

According to her major ymptoms, she is a psychoneu- otic patient with severe nxiety. But according to the escription she gives of her elings, part of the problem ıay sound like depression. his is because her problem, lthough primarily one of ex- ssive anxiety, is often accom- anied by depressive symptom- ology. Valium (diazepam) ın provide relief for both—as e excessive anxiety is re- ved, the depressive symp- ms associated with it are also ten relieved.

There are other advan- ges in using Valium for the anagement of psychoneu- tic anxiety with secondary pressive symptoms: the ychotherapeutic effect of ılium is pronounced and pid. This means that im- ovement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

veillance because of their predisposi- to habituation and dependence. In gnancy, lactation or women of child- aring age, weigh potential benefit inst possible hazard.

cautions: If combined with other psy- otropics or anticonvulsants, consider efully pharmacology of agents em- yed; drugs such as phenothiazines, cotics, barbiturates, MAO inhibitors other antidepressants may potentiate action. Usual precautions indicated in ents severely depressed, or with latent ression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The JOURNAL of the Oklahoma State Medical Association

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(Cover Art By William Cason)

WHY DON'T WE . . .

• Establish an FDA-type agency for bureaucrats which will require proof-of-effectiveness before, during and after approving their pay checks?

• Set up a PSRO for all public officials, elected and appointed, in order to monitor their performance and establish penalties for poor judgment, derelictions and oversights?

• Require periodic re-licensure of all lawyers, judges, accountants, architects and engineers?

• Publicize the payments made to local and federal judges which would include the monetary values of such benefits as retirement programs, office space, vacations, sick leave, health and hospital benefits, transportation and postal allowance and the salaries of all personnel assigned to his court?

• Demand that every graduate of every educational institution which received any federal funds be required to repay the federal government the cost of their education in cash or indentured service?

• Insist that the plaintiff and/or his attorney in a successfully defended medico-legal action be required to pay all the costs of defense, including compensation for time lost and "pain and suffering"?

• Quit paying for malpractice insurance and let our patients recover from the delusion that all physicians are rich?

• Invite our critics to live and work with us for one week every year in order to make them the health-care experts they profess to be?

• Find an easier way to making a living?

MRJ

Professional Liability Program for 1976



The citizens of Oklahoma, including our Legislators, have expressed alarm concerning the increasing cost of professional liability. The increasing number of lawsuits against physicians is also alarming. The number of insurance companies willing to write this type insurance has decreased. In fact, there is only one insurance company who will write this type insurance in Oklahoma. The current Oklahoma State Medical Association liability insurance is written by the Insurance Company of North America. The Oklahoma State Medical Association is considered to have one of the best, if not the best, statewide insurance programs in America. Complacency will not insure our present insurance status. In fact, unless we take steps now, it is virtually assured that we cannot continue to buck the adverse national trend for any length of time in the professional liability insurance field.

The first session of the 38th Oklahoma Legislature of 1975, passed legislative reforms to aid in increasing the number of physicians in the rural areas of Oklahoma. The second session of the 38th Oklahoma Legislature of 1976 must pass further legislative reforms to continue this effort. Our Legislative committee, under the expert chairmanship of Doctor Barton Carl, has recommended a broad based bill, that we hope can be passed in 1976. This bill is known as the Oklahoma Medical Services Act of 1976.

Briefly, this bill would cover the following:

1. *Statute of Limitations.* The new bill would shorten the Statute of Limitations for both adults and children.

2. *Waiver of Privilege.* Where any person has placed his physical or mental condition in issue by the commencement of any action, proceeding or suit for damages or the physical or mental condition of any other person or deceased person by or through whom such person rightfully claims, he shall be deemed to waive any privilege granted by law concerning any communication made to a physician or health care provider with reference to any physical or mental condition or any knowledge obtained by such physician or health care provider by personal examination of any such patient, at the time of the commencement of the action insofar as the privilege would protect information relevant to the physical or mental condition in issue.

3. *Collateral Sources.* In personal injury actions, it is not unusual for the injured party to sustain considerable medical and medical-related expenses. These expenses, which the injured party wants to recover, are identified in the suit and are a part of the total damages asked for in the lawsuit. In some cases, in fact most cases, a considerable amount, of the expenses are offset by *"Collateral Sources,"* ie, health insurance policies, social security benefits, disability insurance, etc. This information is not available to the jury. If the jury makes its award based upon the plea of the injured party and collateral sources are involved, there would be double recovery. We think the information about collateral sources or the lack thereof, should be made available to the jury.

4. *Res ipsa loquitur.* In other words, "the action speaks for itself." In any action arising from negligence in the rendering of medical care, no presumption of negligence shall arise unless the following foundation facts are first established by expert testimony:

(1) The plaintiff sustained an injury.

(2) Said injury was proximately caused by an instrumentality solely within the control of the defendant.

(3) Such injury does not ordinarily occur under the circumstances absent negligence on the part of the defendant.

5. *Ad-damnum Clause.*

6. *Warrantees and Guarantees.* Some lawsuits are filed where the injured party alleges that the physician guaranteed that his treatment or operation would cure the patient. The "oral warranty" is legal grounds for a suit, but probably should not be. On the other hand, a physician should not guarantee his patient a cure unless he is willing to put it in writing. Therefore, we recommend that unless the physician puts in writing his guarantee, warranty, or contract for cure, that the patient can not bring a lawsuit on these grounds alone.

The bill will further provide that any section of the bill can be removed without affecting the other sections.

The points above are those covered in the Oklahoma State Medical Association bill. There will be other separate bills filed for some of the more controversial areas of professional liability, such as, Contingency Fees, Installment of Liability Payments, Limitation of Awards, and possibly a Counter Claim Bill.

I would urge all of the members of the Oklahoma State Medical Association to contact your local Legislators, and ask them to support our cause. Once again, I am asking for a united effort on the part of every OSMA member, for with a united effort, *we will not fail!*

Arnold G. Nelson, M.D.

OSMA JOURNAL / special

Report Of The Attorney General On Medical Malpractice And Insurance

From the office of the Attorney General Larry Derryberry

Prepared by David K. McCurdy Assistant Attorney General

OCTOBER, 1975

DAVID K. McCURDY
ASSISTANT ATTORNEY GENERAL

ACKNOWLEDGMENTS

We wish to express appreciation to the following: Mr. Don Blair, Executive Director, Oklahoma State Medical Association; Mr. George Short, Attorney, Pierce, Couch, Hendrickson and Short; Mr. Rod Frates, Insurance Counselor for the Oklahoma State Medical Association; Doctor Ed Young, Chairman, Oklahoma State Board of Medical Examiners; and Mr. Mark Hain, Legal Counsel, State Insurance Commission, for their valuable assistance.

INTRODUCTION

Throughout the United States there has been a rapid increase in the frequency and size of medical malpractice suits, as well as a number of insurance carriers withdrawing from the malpractice market; all of which have contributed to the heightened concern of the general public, health care professionals, lawyers, and insurers.

This report is presented as an objective study of professional medical liability and is intended to examine the relative nature and extent of the medical malpractice issue in Oklahoma and how it relates to other states. The critical objective of the report is to analyze professional medical liability in Oklahoma, determine whether or not a problem exists and, if so, to enunciate the issues. No solutions or remedies are offered or intended.

There have been a number of studies conducted on medical malpractice at both the state and national levels; nonetheless, the pervasive difficulty in preparing an analysis of the issue is the dearth of statistical data. Much has been written by interested parties creating a surplus of rhetoric, speculation and accusations without critical substantive documentation. This is due perhaps to the fact that there is no uniquely identifiable problem but a complex of problems involving interacting medical, legal, sociological, psychological and economic factors.

Despite its widely publicized accomplishments, medicine can still be considered more art than science, involving individual judg-

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ments by doctors in constantly changing cases and situations. The medical profession would be the first to state that because of the complexities, uncertainties and inherent dangers in modern medicine occasional errors and failures in treatment result in injury to the consumer-patient.

There are a number of factors which have contributed to the dramatic increase in malpractice suits in the United States, including: increased exposure by the public due to readily obtainable medical treatment; augmented use of potent drugs with the commensurate increased danger; relative lack of appreciation of risks involved in medical treatment; change in medical technology with the general shift from the individual family practitioner to treatment by groups, teams and institutions resulting in more impersonal care and deteriorating physician-patient relationship; a more litigation-minded consumer-public; the increased availability and competence of legal aid and counsel; and the greater public interest in medicine and the unrealistic expectations fostered by the press and media.[1,2]

Sundry effects of the increase in medical malpractice suits and awards include rising health care costs to the consumer-patient, altered availability and quality of health care, increased cost and decreased availability of professional liability insurance and further deterioration of physician-patient relationship.[3] It is apparent that there is a host of interested parties involved; primarily concerned are the consumer-patients, health care providers and profession, legal profession, and malpractice insurance providers. For the sake of clarity and organization this report will examine each of the parties constituting the medical malpractice circle.

CONSUMER-PATIENT

The consumer-patient is perhaps the party most often overlooked amid all the clamor and dialogue of the malpractice problem. The patient is the one who will inevitably bear the burden of increased cost of medical care.

The Commission on Medical Malpractice for the Secretary of Health, Education and Welfare found that in 1971 over seventy-five billion dollars, 7.4% of the GNP, and nearly $358 per person was expended for health care services in the United States making it, dollar wise, the second largest industry in our nation.[4]

The increased cost of medical malpractice insurance is passed on to the consumer who, as a result, must pay more for medical care. Throughout the United States over one billion dollars was spent in 1975 for malpractice premiums which, although a mere fraction of the total national health care costs, is significant when paid by the consumer.[5,6]

In Oklahoma, on the other hand, $1,229,149 was expended in 1974 for medical malpractice premiums to INA, the Insurance Company of North America, the Oklahoma State Medical Association malpractice insurance carrier.[7] Clearly this does not reflect a high per patient cost as compared to other states.

The following states . . . California, New York, Pennsylvania, Massachusetts, Florida, Indiana, Maryland, Hawaii, Idaho, Nevada and Alaska . . . are recognized as facing a severe medical malpractice crisis.[8] Again, Oklahoma remains in a relatively auspicious position with respect to insurance rates and availability which results in more reasonable and efficient medical care for the patient.[9]

HEALTH-CARE PROVIDER

In 1974 there were 2,804 physicians licensed to practice medicine in Oklahoma, 2,310 of which were members of the Oklahoma State Medical Association insurance program.[10,11]

In 1967 there were 20 claims reported to INA, six of which resulted in some form of payment. In 1970 there were 120 claims reported, with 35 resulting in payment. For the year 1972 there have been 157 claims reported, with 30 resulting in payment;[12] however, it must be noted that these figures are subject to change due to discovery of any claim at a later period. Based upon the figures for 1970, above, it is apparent that Oklahoma was far below the national average of 6.5 claims paid per 100 practicing physicians.[13]

It is widely recognized that certain specialists are more prone to suit than others. Orthopedic surgeons and anesthesiologists, for example, are more prone to suit because of the nature of the high risk procedures they undertake.

Of further significance is the fact that nationally in 1970, 57.2% of the claims arose from surgical procedures and that 74% of all alleged malpractice incidents occurred in hospitals. Certain hospitals (15%) accounted for more

than one-half of all claims attributed to hospitals.[14]

Due to the dramatic increase in the number and size of suits, the cost and availability of malpractice insurance has become a significant problem for physicians. Oklahoma, however, has not been critically affected as have many states. There appear to be several factors credited with Oklahoma's apparently auspicious position.

First, Oklahoma is not as urbanized as many states and is thus temporarily isolated from many of the primarily urban ills. Specialization, urbanization and an increased consumer demand have all made the doctor-patient relationship highly technical and depersonalized. Accordingly, a malpractice claim is more likely to be filed when a desired or expected medical result is not achieved.

Secondly, Oklahoma physicians appear to have a strong and effective state medical society which provides many benefits, including a group insurance program. As discussed later, the OSMA insurance program provides insurance at an extremely low rate compared to other states. Because of the working relationship between the physician, his society and the insurer, Insurance Company of North America (INA), Oklahoma is *currently* not faced with a problem of excessive rates or unavailability.[15]

Another significant effect of the rise in medical malpractice suits is the practice of defensive medicine. Although not readily subject to statistical analysis, the practice of defensive medicine is prevalent. Defensive medicine is defined as:

> [A]lteration of modes of medical practice, induced by the threat of liability, for the principle purpose of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted.[16]

Defensive medicine clearly adds to health care costs due to increased use of x-ray, diagnostic tests, consultation and extended hospitalization.

The Oklahoma State Board of Medical Examiners is vested with the duty to license and discipline physicians in the state. There are currently three basic procedures whereby a physician may become licensed to practice medicine in Oklahoma. Physicians are currently required to pass either the National Board of Medical Examiners Test (National Boards) or the Federation Licensing Examination (FLEX). Physicians licensed in other states, by successful completion of either licensing examination, may be admitted by endorsement.[17]

The Oklahoma State Board of Medical Examiners is onerated with the duty of disciplining physicians for "unprofessional conduct." Unprofessional conduct is addressed in the statutes:[18]

> The words 'unprofessional conduct' as used in Sections 481 through 541 of this title are hereby declared to include, but shall not be limited to, the following acts:
>
> 1. Procuring, aiding or abetting a criminal operation.
>
> 2. Advertising to the public in any manner; provided, however, that a person, firm, association or corporation may place an announcement in a newspaper regarding the opening of an office, change of an address or membership in a firm, association or corporation, the closing of an office, permanent or temporary, for whatever reason, and the specialty or specialties of person or persons, firm, association or corporation.
>
> 3. The obtaining of any fee or offering to accept any fee, present or other form of remuneration whatsoever, on the assurance or promise that a manifestly incurable disease can or will be cured.
>
> 4. Willfully betraying a professional secret to the detriment of the patient.
>
> 5. Habitual intemperance or the habitual use of habit-forming drugs.
>
> 6. Conviction of a felony or of any offense involving moral turpitude.
>
> 7. All advertising of medical business in which statements are made which are grossly untrue or improbable and calculated to mislead the public.
>
> 8. Conviction or confession of a crime involving the violation of the antinarcotic or prohibition laws and regulations of the federal government or the Board of Health laws and regulations of the State of Oklahoma.
>
> 9. Dishonorable or immoral conduct which is likely to deceive or defraud the public.
>
> 10. The commission of any act which is a violation of the criminal laws of Oklahoma when such act is connected with the physician's practice of medicine. A complaint, indictment or confession of a criminal violation shall not be necessary for the enforcement of this provision. Proof of the commission of the act while in the practice of medicine or under the guise of the practice or medicine shall be unprofessional conduct.
>
> 11. Failure to keep complete and accurate records of purchase and disposal of controlled drugs or of narcotic drugs.

12. The writing of false or fictitious prescriptions for any drugs or narcotics declared by the laws of Oklahoma to be controlled or narcotic drugs.

13. Prescribe or administer a drug or treatment without sufficient examination and the establishment of a valid physician-patient relationship.

14. The violation, or attempted violation, direct or indirect, of any of the provisions of this act, either as a principal, accessory or accomplice.

15. Aiding or abetting, directly or indirectly, the practice of medicine by any person not duly authorized under the laws of Oklahoma.

16. The inability to practice medicine with reasonable skill and safety to patients by reason of age, illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. In enforcing this subsection the Board may, upon probable cause, request a physician to submit to a mental or physical examination by physicians designated by it. If the physician refuses to submit to the examination, the Board shall issue an order requiring the physician to show cause why he will not submit to the examination and shall schedule a hearing on the order within thirty (30) days after notice is served on the physician. The physician shall be notified by either personal service or by certified mail with return receipt requested. At the hearing, the physician and his attorney are entitled to present any testimony and other evidence to show why the physician should not be required to submit to the examination. After a complete hearing, the Board shall issue an order either requiring the physician to submit to the examination or withdrawing the request for examination. The medical license of a physician ordered to submit for examination may be suspended until the results of such examination are received and reviewed by the Board.

Currently the principal findings of unprofessional conduct arise out of drug abuse, either from mishandling or addiction, including alcoholism. The goal of the Board of Medical Examiners in a disciplinary proceeding is the rehabilitation of the physician, as much as possible, with highest regard given for the health and safety of the public.[19]

Annually there are 20 to 25 physicians, approximately one percent of state membership, under surveillance of the Board of Medical Examiners. As reported in the 1975 Annual Report of Board of Medical Examiners there have been 11 personal appearances by physicians before the Board; nine of which were drug-related ranging from violation of narcotic reporting laws to addiction; one aiding and abetting unlicensed practice of medicine; and one application for admission by a physician with former conviction of a felony. Sanctions ranged from a revocation of license to several five-year probations with various restrictions on practice, especially in regard to the handling of drugs.[20]

In addition to the police function of the Board of Medical Examiners, it is recognized that local and state medical associations and hospital medical staffs provide another check and balance on medical competency.

LEGAL SYSTEM AND PROFESSION

Increases in the size and number of judgments, expansion of legal doctrines, meritless suits, and excessive contingency fees are just a few of the accusations currently directed at malpractice attorneys and the legal profession. Such accusations are difficult to document or analyze and almost impossible to reduce statistically.

There is evidence in Oklahoma that the average number and size of judgments has increased in recent years.[21] While this report was being prepared, a jury in Oklahoma County on September 27, 1975, granted plaintiffs an award of $280,000, the largest such award in a malpractice suit in Oklahoma history.[22] It is significant that during the same week a jury in the same county also awarded the largest verdict of $1.8 million in a personal injury suit.[23]

There is a host of legal doctrines which significantly influence the initiation and outcome of malpractice claims and suits, among which are: res ipsa loquitur, the discovery rule, informed consent, oral guarantees of results of treatment, strict liability, Good Samaritan, conspiracy of silence, waiver of privilege, collateral source, ad damnum, and contingent fee.

Malpractice has been defined as "the treatment by a surgeon or physician in a manner contrary to accepted rules and with injuries resulting to the patient."[24] The American Medical Association defines malpractice as:

> [A]n unwarranted departure from acceptable medical practice resulting in injury to patient. A mere error in judgment is not malpractice, but a failure to obtain sufficient data on which to base a sound judgment may be malpractice.

> A course of action cannot be excused as a mere error in judgment if it is contrary to the accepted standard of medical care of other physicians in the locality engaged in the same type of practice.[25]

The word "malpractice" is a misnomer, for it has connotations of malevolence which is rarely the basis of the action. A more accurate term is professional liability or professional negligence. There are three essential elements in malpractice: 1) relationship between physician and patient, 2) physician departure from some duty which he owed to the patient, and 3) the departure being the proximate cause of the injury.[26]

Res Ipsa Loquitur.

The doctrine of res ipsa loquitur, Latin for "the thing speaks for itself," is an evidentiary rule that is permitted to be invoked when (1) an injury occurs which is of the type that ordinarily does not occur except for someone's negligence, (2) the conduct or mechanism which caused the injury was within the exclusive control of the person from whom damages are sought, and (3) the complaining party was free of any contributory negligence.[27] When these conditions are established, the burden of proving negligence by the plaintiff is shifted to the defendant who must then prove that he was not negligent.

Physicians argue that the doctrine of res ipsa loquitur is used differently in malpractice cases than in other types of tort litigation. There is evidence that the doctrine has been liberally construed in recent years with other states broadly extending the doctrine.[28] Oklahoma defense attorneys fear that this construction has the resulting effect of making the doctor "guilty until proven innocent."

The HEW Commission on Medical Malpractice found that:

> . . . [T]he doctrine of res ipsa loquitur in its classical sense performs useful purpose in common law, but that it should not be applied differently in medical malpractice cases than in other types of tort litigation.[29]

Discovery Rule.

The general statute of limitations in tort actions in Oklahoma is two years.[30] Such a limitation requires the complaining party to file his lawsuit within the allotted time. The statute of limitations is intended to avoid such problems as loss of witnesses and relevant evidence over an extended period of time. Generally in personal injury cases the statute of limitations begins to run from the time of the alleged negligent event. However, in medical malpractice there are instances when the patient does not discover the nature or extent of the injury until the statute of limitations has run. Accordingly, courts have generally held that the statute does not begin to run until the patient knows, or reasonably should have known, that the negligent act occurred.[31]

It is often argued, and discussed in detail later, that the discovery rule is one of the primary factors contributing to malpractice problems today. Although the greatest number of suits occur within the first two years, the fact that a suit may not be instituted for years after the negligent event occurred prevents accurate actuarial computation of malpractice insurance rates. It is, therefore, apparent that the state must weigh the benefits of extended recovery for patients under longer statute of limitations against the value of more accurate actuarial determination and the ensuing insurance market stability.

Informed Consent.

The doctrine of informed consent has been defined as:

> [T]he consent given by the patient to the provider of care, usually in writing, authorizing the institution of treatment or a specific surgical procedure, after the patient has been apprised of all the risks of the proposed course of treatment of procedure and alternate course of treatment other than the one proposed, in order that the patient can make a free and intelligent decision as to whether or not to undergo the treatment or procedure.[32]

In short it means that the patient is to be informed of the procedure and risks involved in order to expressly or impliedly consent to treatment. Informed consent has recently been expanded to impose an affirmative duty of disclosure on the physician whether or not the patient inquires as to specific risks.[33]

One of the leading Oklahoma defense attorneys recently stated that informed consent has, in effect, merely become another element of negligence. The Commission on Malpractice for HEW found that "the doctrine of informed consent is subject to abuse when it imposes an unreasonable responsibility upon the physician."[34]

Oral Guarantees of Results of Treatment.

A physician owes the patient a duty to exercise due care and skill in the treatment he renders. However, there has been an increase in the number of patients who have taken advantage of the longer contract statute of limitations and have sued for breach of an oral contract. The Commission for HEW stated that to allow a patient to sue under this contract theory solely to avoid the shorter tort statute of limitations was establishing a perilous precedent.[35]

Strict Liability.

The theory of strict liability has recently been applied in products liability cases against drug manufacturers, blood banks, etc. Traditionally blood banks were regarded as medical services, but in recent years they have been regarded as selling a "product." There is some criticism as to the application of this doctrine.[36]

Good Samaritan.

The Good Samaritan statute is designed to provide protection for a physician who renders emergency care and treatment.[37] There is, in fact, no reported case in Oklahoma in which a physician has ever been sued under such a condition.

Conspiracy of Silence.

Traditionally plaintiff's attorneys were heard to complain about the unavailability of a medical expert witness willing to testify against a fellow physician. Such theory was commonly referred to as the "conspiracy of silence." Informed sources today not only deny that there is such a conspiracy but add that in a number of cases physicians have been reluctant to testify on behalf of a physician facing suit.

Waiver of Privilege.

As in a number of professions, physicians are bound to the physician-client privilege of confidentiality. It is arguable that such a privilege can work to the detriment of a physician with regard to obtaining the medical records of a patient.

Collateral Source.

Traditionally, evidence of insurance or collateral source of payment to a patient has been inadmissible in court. There has been considerable question raised as to the desirability of such a rule when the underlying theory of suit is compensation. On the other hand, the rule has been defended by asserting that the injured person should be compensated for expenses, pain and suffering, and inconvenience.

Ad Damnum.

The ad damnum clause is the specific dollar amount in the damages sought by the plaintiff in a lawsuit. It is found that the amounts prayed for often bear little relationship to the sums actually expected or obtained.[38] Many believe that the ad damnum clause is a source of friction between lawyers and physicians since it is common practice to insert exaggerated amounts in an ad damnum clause.

The HEW Commission stated:

> These large demands attract sensational newspaper coverage, impose needless anxiety and often unfounded notoriety upon defendant physicians, creating a feeling of unfair prosecution in the medical world and are of no special benefit to the plaintiffs patients.[39]

Contingent Fee.

Perhaps no characteristic of the legal system is blamed more by medical providers as a direct cause of the malpractice problem than the contingent fee for attorneys. The contingent fee is an arrangement between an attorney and his client whereby the attorney will take the case with the understanding that he will be paid only if the client is successful and is actually awarded damages. In Oklahoma it is not uncommon for an attorney to receive a contingent fee of fifty percent of the award in malpractice suits.

The contingent fee is criticized as resulting in frivolous suits, magnified awards to compensate for the contingent fee, and exorbitant remuneration to the attorney. James D. Fellers, an Oklahoma City attorney and past President of the American Bar Association defends the contingent fee arrangement and states:

> First, mere vexations, non-meritorious claims are frequently stopped before they get underway. Most lawyers will simply not get in-

volved in 'crank' demands against doctors when the suit is to be filed on a contingency.

Second, persons who cannot afford to shoulder the financial burdens of contested litigation until an award is received are not prevented from bringing a creditable action when the suit is on a contingent basis. So, a fee arrangement dependent on success certainly has some virtue in at least these two frequently encountered situations.[40]

Fellers further stated that in general only one out of every four malpractice suits are successful.

The HEW Commission on Medical Malpractice studied the effect of the contingent fee on a national level and made several findings:

(1) . . . [T]he contingent fee arrangement discourages the acceptance of meritorious low-recovery cases. However, Commission further found that on a fee for service basis, potential clients would be similarly discouraged from pursuing these same meritorious low-recovery cases, since the average citizen cannot financially support the required lawyer's services.

(2) . . . [V]irtually all plaintiff attorneys use a contingent fee arrangement in medical malpractice cases, and the commonly used contingent fee rate is 33 1/3% of the recovery. Some attorneys use a sliding scale of fee rates depending on the state of the claim at the time of the case's final disposition.

(3) . . . [B]y analytically reducing average plaintiff lawyer's contingent fees to an hourly basis for comparison purposes, there does not appear to be any gross discrepancy between the resultant rates charged by the plaintiff bar and those charged by the defense bar in medical malpractice cases.

(4) . . . [W]hen, under a contingent fee arrangement, a plaintiff attorney loses a case he will have invested a considerable amount of uncompensated time on that case.[41]

A number of jurisdictions have adopted a sliding scale for contingent fees such as that enacted in New Jersey:

(1) 50% on first $1,000 recovered, (2) 40% of next $2,000, (3) 33 1/3% on $47,000 recovered, (4) 20% on next $50,000 recovered, and (5) 10% on amount received over $100,000.[42]

MALPRACTICE INSURANCE AND THE INSURANCE PROVIDER

Medical malpractice insurance is a necessity for physicians and health care providers in today's society. Rising costs and declining availability of medical malpractice insurance have been a major source of concern for physicians. Professional liability insurance performs the dual function of providing indemnity for the physician and is the major source of compensation for most patients injured due to the health-care providers' negligence.[43]

Professional liability or malpractice insurance possesses distinctly different characteristics from other forms of insurance. The premium volume for physicians is relatively small compared to other insurance programs. Unlike automobile insurance and other lines, malpractice insurance losses occur irregularly and are known for catastrophic amounts. Accordingly, it is difficult to determine an average claim cost. Perhaps the greatest single problem is the length of time from claim to final disposition, referred to as the "Long Tail." Because of these unique features, it is extremely difficult to analyze medical malpractice programs.

Currently there are 2,310 physicians in the Oklahoma State Medical Association (OSMA) sponsored insurance program, which represents virtually every practicing physician in Oklahoma. The basic program offers a $100,000 primary policy with Insurance Company of North America (INA) and an optional umbrella policy with Continental National American (CNA). Each individual physician has a separate contract with the insurer and, in that sense, the OSMA sponsored plan is technically not a group program. There are significant reasons and advantages advanced for gross participation in group association programs.

A state association sponsored program can offer lower premium rates by allowing one insurer to write the bulk of the policy in order to provide sufficient premiums to offset potential losses. If the insured physicians are members of a state society it affords an additional police power in the malpractice area.

The Oklahoma State Medical Association currently maintains a contract with its insurer, INA. The significant provisions of the contract are:

1. The program can be cancelled only after six-months notice prior to any anniversary date, which is January 1 of each year.

2. Six-months notice is required before any change of terms or conditions can be made in the policy.

3. Rates can be amended only after six-

months notice to physicians with documented proof of loss experience to justify rate changes. (Note: This is in addition to the required approval by the State Board of property and casualty rates.)

4. Members have a council on insurance which provides a right of appeal should the insurer wish to cancel any member physician due to an adverse loss experience or other reason. INA is required to give notice to the Council on insurance before cancelling any physician.[44]

Malpractice insurance rates are divided according to the risks involved in the respective practice. In Oklahoma there are five classes:[45]

TABLE I

Class	Classification	No. of Members	Rate
Class I	Physicians—no surgery and low risk specialties.	808 members	$202 per year
Class II	Physicians—minor surgery or assisting in major surgery on own patients and low risk specialties.	196 members	$358 per year
Class III	G.P. major surgery and surgeons, ophthalmologists, proctologists.	543 members	$709 per year
Class IV	Surgeons-specialists, cardiac surgeons, thoracic, urologists, vascular surgeons.	293 members,	$945 per year
Class V	Surgeons-specialists—anesthesiologists, neurosurgeons, ob-gyn, otolaryngologists, plastic surgeons.	398 members	$1,180 per year

From a comparative standpoint, the OSMA program appears to have some of the lowest premium rates in the United States.[46,47] Next year the OSMA program will increase its rates by 35% and has established a stabilization fund to provide additional protection from increased suits and awards. The net effect is a 50% increase in the cost per individual physician.[48]

As justification for the rate increase INA provided the OSMA with their trending and loss development factors. The table below includes the premiums paid per year, INA's projected losses, and OSMA's estimate of INA's projected losses.[49]

TABLE II

Year	Premium	INA's Developed, Plus Trended Losses and Allocated Expenses	OSMA's Estimate of INA's Losses and Expenses	Claims
1972	$ 907,000	$1,640,000	$571,178	157
1973	$1,152,319	$2,840,000	$827,471	190
1974	$1,229,149	$2,170,000	——	115

As can be seen there is considerable variation between INA's estimated losses and OSMA's estimate of INA's losses. Due to the complexity of the formula for developing trending factors and loss development factors, much of the formulation is speculative. Therefore, INA and OSMA have compromised on the percentage of increase in rates. A further caveat must be interposed by a short discussion of the most significant variable in the formulation process, the "Long Tail."

The "Long Tail" is basically the time elapsing between an alleged incident of malpractice and the claim thereof. As previously stated, because of the unique features of medical malpractice, as well as the statute of limitations and discovery rule, certain claims are able to surface a number of years after the malpractice incident. For the 1969 reporting year some claims arose five years after the reported event.[50] Because of this feature and the fact that malpractice claims are irregular in frequency it becomes obvious that insurers will be guarded in their forecasts.

Unavailability of malpractice insurance continually looms as a possible problem. A number of factors contribute to this dilemma, but most notably is the sudden cancellation by insurers. OSMA contends that due to their good record on medical malpractice and their working relationship with INA there is little fear of sudden cancellation or insurance unavailability. OSMA further maintains that since the Association competitively bids the entire program on the policy anniversary, the

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HOW STATES ASSESS THE AVAILABILITY OF COVERAGE
(Source: Prism Survey of State Associations, June, 1975)

I. Serious Problem Exists	II. Problem Developing	III. Possible Future Problem	IV. Minor or no Problem	
Alaska	Arizona	Alabama	Colorado	New Jersey
California	Arkansas	Mississippi	Connecticut	New Mexico
Florida	Hawaii	Washington	Delaware	North Dakota
Maine	Iowa		District of Columbia	Oklahoma
New York	Kansas		Georgia	Pennsylvania
Ohio	Kentucky		Idaho	Rhode Island
South Carolina	Illinois		Indiana	Utah
South Dakota	Iowa		Louisiana	Vermont
Tennessee	Michigan		Maryland	Virginia
Texas	Missouri		Massachusetts	West Virginia
	Nevada		Minnesota	
	North Carolina		Montana	
	Wisconsin		Nebraska	
	Wyoming		New Hampshire	

AVERAGE PAYMENT PER CLAIM

Year of Event	Total Number Claims Reported	Total Amount Paid Claims	Number of Claims Paid	Average Payment Per Claim	Largest Paid Claim	Open Claims
1967	20	$ 18,900.	6	$ 3,150	$ 13,500.	0
1968	48	31,030.	14	2,216.	8,500.	1
1969	65	306,726.	20	15,336.	66,666.	1
1970	120	135,269.	35	3,865.	22,758.	10
1971	127	144,774.	27	5,362.	42,500.	30
1972	155	122,624.	30	4,087.	27,500.	70
1973	157	166,381.*	15	11,092.	125,000.	90**
1974	62	22.	1	22.	22.	52
1975	−0−					

*$125,000. of this amount was paid on two claims resulting from one incident.
**26 of these open claims are one incident involving an osteopath denied hospital privileges. The reserves set are $100. per doctor/insured.

PREMIUM INCREASES SINCE INCEPTION
1967 thru 1975

	Class I	Class II	Class III	Class IV	Class V
1967	$134.00	$167.00	$321.00	$482.00	*n/a
1968	134.00	167.00	321.00	482.00	n/a
1969	134.00	167.00	321.00	482.00	n/a
(Increase eff. 1-1-70)	(1.14%)	(1.61%)	(1.44%)	(1.28%)	n/a
1970	153.00	269.00	461.00	616.00	$ 769.00
1971	153.00	269.00	461.00	616.00	769.00
1972	153.00	269.00	461.00	616.00	769.00
(Increase eff. 1-1-73)	(1.10%)	(1.10%)	(1.28%)	(1.28%)	(1.28%)
1973	169.00	297.00	590.00	786.00	983.00
1974	169.00	297.00	590.00	786.00	983.00
(Increase eff. 1-1-75)	(1.20%)	(1.20%)	(1.20%)	(1.20%)	(1.20%)
1975	202.00	358.00	709.00	945.00	$1,180.00
8 Year Increase:	151%	214%	221%	196%	153%

* Class V surgeons were not added until 1970. Until that time, they were considered Class IV.

PROFESSIONAL LIABILITY INSURANCE
INA — ANALYSIS OF LOSSES
(As of February 28, 1975)

POLICY YEAR	EVENTS REPORTED DURING POLICY YEAR		+ 1 YEAR		+ 2 YEARS		+ 3 YEARS		+ 4 YEARS		+ 5 YEARS		TOTAL REPORTED
	%	#	%	#	%	#	%	#	%	#	%	#	
1967	80%	16	15%	3	5%	1	5%	1					20
1968	68%	34	20%	10	12%	6							50
1969	49%	32	26%	17	9%	6	11%	7	3%	2	2%	1	65
1970	42%	51	27%	32	29%	35	1%	1					120
1971	40%	51	34%	43	22%	29	4%	5					128
1972	37%	58	28%	43	34%	53	1%	2					156
1973	49%	74	51%	78									152
1974	90%	54	10%	6									60

members are afforded the best possible insurance program.

CONCLUSION

Medical malpractice is a complex and multifarious problem possessing potentially disastrous impact upon the health-care profession and the general public. Oklahoma presently occupies a relatively propitious position regarding malpractice litigation and insurance. It is manifest, however, that Oklahoma's position is indeed precarious in light of the salient national trend to the contrary.

It is, therefore, apparent that enactment of some preventive or prophylactic legislation is essential to forestall any future expansion and intensification of the medical malpractice problem in Oklahoma.

BIBLIOGRAPHY

American Bar Association, "The Medical Malpractice Crisis in Insurance: How it Happened and Some Proposed Solutions", August 12, 1975.

Fellers, Barrister, "When Doctors and Lawyers Clash", Summer, 1975.

Council of State Governments, State and Medical Malpractice, 1975.

Oklahoma State Board of Medical Examiners 1974 Annual Report.

Oklahoma State Medical Association, Mr. Don Blair, Executive Director.

Oklahoma State Medical Association, Medical—Legal Guide for Physicians, 1969.

Review, "Malpractice Muddle", 1975.

Trial, Volume II, Number 3, March/June, 1975.

U.S. Department of Health, Education and Welfare, Office of Secretary, "Report of Secretary's Commission on Medical Malpractice", January 16, 1973, Government Printing Office, Department of Health, Education and Welfare Public Notice (OS) 73-88.

U.S. News and World Report, January 20, 1975.

TABLE OF CASES

Canterbury v. *Spence,* 464 F. 2d 772 (1972).

Cox v. *Kelsey-Hayes,* CJ-74-2175.

Henderson v. *Metcalf,* CJ-74-2129.

OKLAHOMA STATUTES CITED

Title 12 O.S. 1971, §95.

Title 59 O.S. 1971, §518.

Title 59 O.S. 1974 Supp., §509.

MISCELLANEOUS

70 C.J.S., Physicians and Surgeons, §40.

REFERENCES

1. U.S. Department of HEW, Office of Secretary, "Report of the Secretary Commission on Medical Malpractice", January 16, 1973, Government Printing Office, Department of HEW Public Notice (OS) 73-88.
2. Trial, Vol. II, Number 3, May/June, 1975.
3. The States and Medical Malpractice, Council of State Governments, 1975.
4. HEW, supra.
5. Id.
6. U.S. News and World Report, January 20, 1975.
7. Oklahoma State Medical Association.
8. American Bar Association, The Medical Malpractice Crisis in Insurance: How it Happened and Some Proposed Solutions, August 12, 1975.
9. Id.
10. Board of Medical Examiners 1974 Annual Report.
11. OSMA.
12. Id.
13. HEW, supra.
14. Id.
15. Appendix No. 1, How States Assess the Availability of Coverage.
16. HEW, supra.
17. Board of Medical Examiners.
18. Title 59 O.S. Supp. 1974, §509.
19. Board of Medical Examiners.
20. Id.
21. Appendix No. 2, Average Payment Per Claim.
22. *Henderson* v. *Metcalf,* CJ-74-2129.
23. *Cox* v. *Kelsey-Hayes,* CJ-74-2175.
24. 70 C.J.S., Physicians and Surgeons, §40.
25. OSMA, Medical-Legal Guide for Physicians, 1969.
26. Medical Malpractice, PLI, 1972.
27. Id.
28. HEW, supra.
29. Id.
30. Title 12 O.S. 1971, §95.
31. Trial, supra.
32. Review, Malpractice Muddle, 1975.
33. *Canterbury* v. *Spence,* 464 F.2d 772 (1972).
34. HEW, supra.
35. Id.
36. Id.
37. Title 59 O.S. 1971, §518.
38. HEW, supra.
39. Id.
40. Fellers, Barrister, When Doctors and Lawyers Clash, Summer, 1975.
41. HEW, supra.
42. Id.
43. Id.
44. OSMA, supra.
45. Id.
46. ABA, supra.
47. HEW, supra.
48. OSMA, supra.
49. Appendix No. 3, Premium increases from 1967 through 1975.
50. Appendix No. 4, Analysis of Losses.

in purpose of drug information the patient is to get his coopera- n in following a drug regimen.

eparation and distribution of tient drug information

We would hope to amass infor- ation from physicians, medical cieties, the pharmaceutical indus- and centers of medical learning. e ultimate responsibility for uni- m labeling must, however, rest h the Food and Drug Administra- n. There is nothing wrong with s agency saying, "this informa- n is generally agreed upon and erefore it should be used," as long our process for getting the infor- ation is sound.

Distribution of the information a problem. In great measure it uld depend on the medication in estion. For example, in the case an injectable long-acting proges- one, we would think it mandatory ssue two separate leaflets—a ort one for the patient to read be- e getting the first shot and a long e to take home in order to make a cision about continuing therapy. this case, the information might put directly on the package and removable at all. But for a medi- ion like an antihistamine this ormation might be issued sepa- ely, thus giving the physician the ion of distribution. This could serve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

---

ly the doctor can remove that fear 20 or 30 minutes of conversation.

I'm not suggesting that we hhold any information from the ient because, first of all, it would totally dishonest and secondly, it uld defeat the very purpose of the ert. I do think that a patient on the th control pill should know about incidence of phlebothrombosis.

If you're going to tell a patient incidence of serious adverse re- ions, then you have to tell him t a concerned medical decision s made to use a particular medi- ion in his situation after careful nsideration of the incidence of mplications or side effects.

otionally unstable patients pose pecial problem

There are patients who, be- se of severe emotional problems, uld not handle the information ntained in a patient package in- t. Yet if we are going to have a kage insert at all, we just can't e two inserts. I think we might ply have to tell the families of se patients to remove the insert m the package.

gal implications of the patient kage insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
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P·M·A

News From The Oklahoma State Department of Health

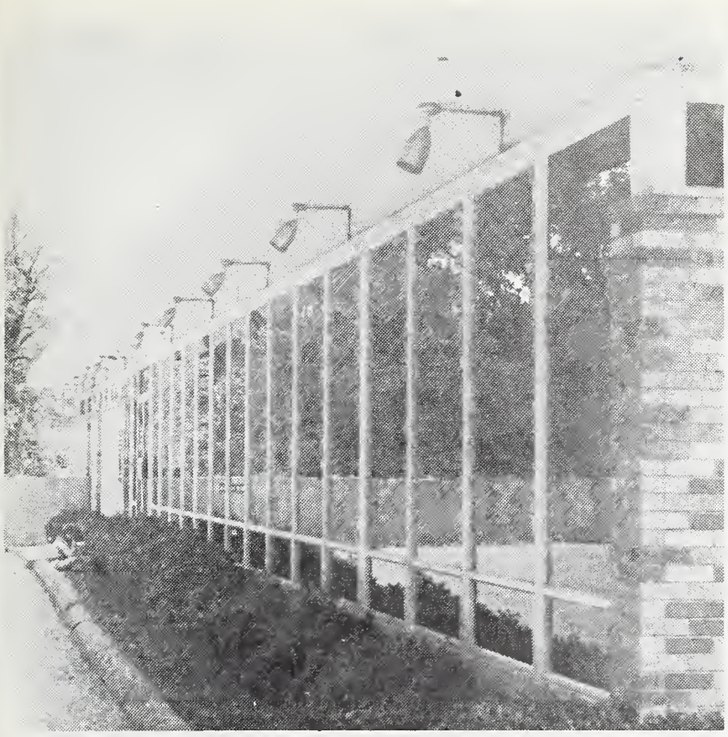
This is to give advance notice of the department's intent to begin proceedings to revise the radiation protection regulations for Oklahoma. The proceedings to revise the regulations will begin with a review of nationally recognized suggested regulations for the control of radiation; such review is underway presently. The proposed revised regulations will be considered by the Radiation Advisory Committee in a series of meetings, for which the dates have not yet been established. Finally, after consideration by the committee, the proposed regulations will be considered for adoption by the State Board of Health in public hearing.

The contents of the proposed regulations are outlined by the following titles of the Parts: Part A, General Provisions; Part B, Registration of Radiation Machine Facilities; Part C, Licensing of Radioactive Materials; Part D, Standards for Protection against Radiation; Part E, Radiation Safety Requirements for Industrial Radiograph Operations; Part F, X-rays in the Hearing Arts; Part G, Use of Sealed Radioactive Sources in the Healing Arts; Part H, Radiation Safety Requirements for Analytical X-ray Equipment; Part I, Radiation Safety Requirements for Particle Accelerators; Part J, Notices, Instructions and Reports to Workers; Inspections. A single copy of one or more of these Parts may be obtained upon request in writing to the Occupational and Radiological Health Service, State Department of Health, P.O. Box 53551, Oklahoma City, Oklahoma 73105. Persons wishing to make written comments on the proposed regulations or to appear at a meeting of the Radiation Advisory Committee to present oral comments should indicate such interest by writing to the address given above. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR NOVEMBER 1975

DISEASE	November 1975	November 1974	October 1975	Total To Date 1975	1974
Amebiasis	1	3	5	31	27
Brucellosis	—	2	—	3	11
Chickenpox	159	129	75	1244	1006
Encephalitis, Infectious	3	4	9	57	55
Gonorrhea (Use Form ODH-228)	982	1009	1239	12050	10395
Hepatitis, A, B, Unspecified	87	117	52	793	950
Leptospirosis	—	1	—	—	2
Malaria	—	—	—	2	6
Meningococcal Infections	3	2	1	13	18
Meningitis, Aseptic	2	5	12	81	63
Mumps	82	24	20	301	405
Rabies in Animals	4	13	9	103	155
Rheumatic Fever	2	—	1	10	12
Rocky Mountain Spotted Fever	—	6	2	90	66
Rubella	6	8	3	95	66
Rubella, Congenital Syndrome	1	—	—	2	1
Rubeola	4	—	12	148	29
Salmonellosis	23	18	40	253	255
Shigellosis	15	24	12	300	174
Syphilis, Infectious (Use Form ODH-228)	6	12	15	86	133
Tetanus	—	2	—	—	3
Tuberculosis, New Active	28	12	19	291	271
Tularemia	—	—	—	9	18
Typhoid Fever	—	—	1	1	2
Whooping Cough	1	3	1	28	19

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A Visit With the Governor

Rarely has one session of the legislature promised to have such a pronounced effect on the future of the medical profession. The Oklahoma State Medical Association has drafted recommendations designed to help remedy some of the many problems now facing medical doctors throughout the state, but if these recommendations are to have any bearing on final decisions, the support of the legislature, the public and the governor is essential.

In order to assess the governor's feelings on the professional liability crisis, utilization review and the many other issues which promise to affect the profession, *The Journal* arranged for this interview with Oklahoma Governor David L. Boren.

Q. Governor Boren, the fastest growing and probably the most troublesome problem facing physicians in this state and across the nation is the professional liability insurance crisis. What do you consider to be the primary cause of this problem and do you see any solution?

A. I'm afraid the main problem is a simple move by many people to try to get something for nothing. I really feel it's a social problem brought on by a number of things, and it's causing a lot of litigation that's really not justified. I do think it speaks very, very well of Oklahoma and the values that our people hold, and also the way medical profession is regarded in the state that it hasn't hit us as hard as it has other states. But I don't have any particular answer to the problem. The officers of the State Medical Association tell me that they will be presenting me with a draft recommendation of a professional liability bill. I'll be very, very sympathetic toward getting something enacted now before the problem actually hits. It's really people taking unfair advantage of a profession. The medical profession has its own ethical obligations and responsibilities to help other people. Doctors can never get to the point where they have to start screening patients' reliability as far as whether or not they think they're moral or ethical before they treat them because the doctor has a strong commitment to treat anyone who needs help.

I have a very high regard for the medical profession and its ideals. To me it's a sign of a social sickness in our country that this kind of problem has developed. So I'm going to be very sympathetic to any legislative proposals which the State Medical Association makes. I have no sympathy whatsoever for people who use non-meritorious lawsuits as a means of bettering themselves financially. And this is really quite frankly what is happening across the

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Governor David Lyle Boren, Governor of the State of Oklahoma

country. A lot of people try to spot anybody who has financial resources, no matter what profession they're in, and they try to find a basis for getting some of those resources. However, the situation is not nearly as bad in Oklahoma.

I think we still are deep believers in the work ethic. I think we realize that we express ourselves through our work. I think the people in Oklahoma are less inclined to want to receive a check for doing nothing, or to receive a check that they're not justly entitled to. This goes all the way to bringing a lawsuit that they don't think they're justly entitled to bring. I think that's a great tribute to our people. Of course, this is one of the reasons I wanted to see us keep that attitude alive in Oklahoma. It's one of the reasons I've been so strong for welfare reform and for making sure that people don't get the idea that they can have something for nothing, and I think we're doing that in Oklahoma. It's why a lot of people want to come to Oklahoma too. I just noticed in a national news magazine that we rank in the top ten of the country in personal income increases.

That's a great tribute to the state. And I really think the reason people want to come to Oklahoma and to invest in Oklahoma is because we have people who still believe in what might be called old-fashioned virtues. That is, "I want to work for what I'm paid, and I don't want something I'm not entitled to." That's a very strong feeling that's given our state a high standard of productivity, and it reflects itself in this area for example in not having as big a problem as other states. I just hope we never do, but I think it would be foolish for us not to take precautionary steps.

Q. You mentioned people coming to Oklahoma because of our work ethic and our favorable outlook. Do you think the national insurance crisis could cause physicians to move to this state, and do you think this could help solve our rural health problems?

A. This is very possible. In other words, when we talk about people coming to our state it may be that more and more doctors will be attracted to Oklahoma as a result of the favorable situation here. I think that we can't simply sit back, though, and wait for the medical personnel shortage in our rural areas to be solved by people that come here because it's gotten so bad in other states. I think we need to take positive steps and we're doing that.

I have ranked improvement in medical education and the proper distribution of medical services as one of the top priorities in my administration. I have done this for a number of reasons. When you come into office and look at figures showing that about ten per cent of our medical personnel are where about 40 per cent of our people live, you realize the tremendous potential for problems. When you look at the mortality rate and you see that someone who has a medical emergency is three or four times more likely to die in an automobile accident if it happens in an rural area where adequate emergency medical care is not available, you have to be concerned. We have tried to attack this in a number of ways.

First of all, we realize that we are not investing wisely if we graduate people from our medical schools and then have no place for them to stay in the state and carry through their residency program. I think the figures show (when I became governor) that we're graduating approximately 150 from the medical school, but we had places for only about 80 as far as residency positions were concerned.

That's bad economy and we, of course, this last year, created the Physician Manpower Training Commission, through a bill which was drafted partly in my office and was part of my program. This Commission has as its goal the creation of more residency positions in the state, particularly new residency positions at satellite medical training areas and smaller community hospitals out across the state. We found that approximately 70 per cent of the physicians locate their practices where they did their residency work. Not only do we want to keep these people in the state, we also want to bring the residency positions, as much as possible, out into smaller communities and regional medical centers. We need to expand the residency programs in our large cities too, but we're also trying to do it statewide.

We have coupled this with the rural medical scholarship program which we have doubled in size and dollar availability. Also, the Physician Manpower Training Commission is making matching grants available to smaller communities to enter into specific contracts with medical students to come practice there when they're through medical school. That way, a student will not only have a contract with the

state to practice in a smaller community, the student will also have a contract with a particular community, and we hope that this is going to help.

My goal, when my term of office is over three years from now, is to have enough residency positions to take care of all those who graduate from medical school in Oklahoma each year, and to have a better distribution of these residency positions. I want not only to expand the number in urban areas, but also to greatly expand the number in rural areas. I also want to have more money in the rural medical scholarship program, more money in the community matching program, and also to expand it not only to just include doctors, but also to have a rural nurse scholarship program as well so that we can also attract qualified nurses into the rural areas.

Another thing that we have done this year, and I'll be asking for a $500,000 increase in our grants to local communities for emergency medical services, is to establish an Emergency Medical Services Coordinating Committee in Oklahoma for the first time, and we have trained many, many people. We have been working with the doctors of the Oklahoma Trauma Research Society. We have been getting local doctors in hospitals across the state involved in the training of emergency medical technicians. We hope to be able to train 3,000 emergency medical technicians in the state of Oklahoma in the next two-year period. This will be a significant increase in the kind of medical service that people in rural Oklahoma are getting. So these are very, very important goals for me, and I've been very pleased with what's been done already, but we are constantly expanding. We're putting more money into rural medical scholarship programs, more money in the creation of new residency positions in both urban and rural areas, more money in the rural nurse program, more money in the emergency medical service program, but even more important, we are training emergency medical technicians.



Q. Governor, in recent years, the Health Sciences Center has experienced some serious financial problems. What kind of commitment do you have for the center?

A. We have increased funding for the Health Sciences Center and medical education this last year by 30.6%. I was very disturbed when I came into office about problems at the center. As a member of the Legislature, I had seen the morale of our Health Sciences Center really go down. This disturbed me because we had attracted some of the best people in the country, and many of them had left and many of them were thinking about leaving because they really wondered if the state had a commitment to quality medical education. I wanted to dispel that kind of feeling.

I think the morale is much higher today than it was. I asked the State Regents to fully fund the request of the medical school last year, and I am going to ask them to continue to give priority treatment to medical education this year when the budget requests are submitted. That's important, and it's quite a break from the past. Generally, the State Regents just take the money that all of the educational institutions request, and if they have only half as much money as what's requested, then they give everybody half of what they asked for. Well, this year instead of doing that they fully funded the Medical Center's request. This is a great step forward.

I think it was very important at that time, because we had to restore morale and confidence, and to get people thinking positively. Now we're seeing it. I think that the coordination that we're getting is important too. We're getting very fine cooperation and coordination between the public sector and the private sector in medical education in Oklahoma. For example, we are being more careful in having our private and our public hospitals specialize in different areas. There is a very cooperative spirit. Things like the new eye institute, where the private sector has come in and raised all

the funds in order to build in Oklahoma an outstanding institute for the treatment of visual problems are very important; this shows the spirit and I think the confidence people are getting again as far as the commitment of the state to doing its part for medical education. Private donations simply couldn't be raised in an atmosphere in which there was not a renewed confidence that we really mean what we say about putting priority on the adequate educational funding for medical services.

Q. So you would say medical education is a top priority item in your administration?

A. It very definitely is. And of course, I've been involved in it from the point of view of trying to build new state programs that make sense from the point of view of providing better medical service, like funding for medical education and like the new Physician Manpower Training Commission and the rural medical program.

I have also tried to get involved in presenting from the state and local level, some views to those who are making national policy on medical matters. For example, the whole question of utilization review. As you know, I became very involved in that as Governor. That program was going to have a devastating effect on Oklahoma, particularly on our smaller hospitals. I have to say with all candor that I don't think it makes very much sense for a hospital of any size, but it certainly would have been devastating as far as small hospitals are concerned. You didn't have enough uninvolved doctors there who could perform peer review.



In the name of improved medical service, we took a very leading role in getting it stopped.

I've been very active in governors' conferences and in obtaining support from other governors against these kinds of HEW regulations. And of course, Mr. Rader has been very, very active in opposing these regulations and in trying to help us find a way around them. I really think that Oklahoma physicians played as important a role as physicians from any state in this entire country in getting the utilization review guidelines modified to the extent that they have. I still wish we didn't have as much as we're going to have to have, but, when you look at where we started and how bad the federal guidelines were that we were operating under, I think it's been a major victory that we've been able to get them modified to the extent that we have. We're working now to get the standards on the care for the mentally retarded in Oklahoma changed. This is another area that those in the medical field happen to have a great interest in and a great expertise, and we're facing some very unreasonable regulations there also.

Q. Governor, you recently appointed Oklahoma's Health Systems Agency, and your appointments and the agency's organization caused a great deal of controversy. Could you explain your thoughts on HSA?

A. We were going to be forced into a situation in Oklahoma in which we either had to have four or we had to have one HSA. Again, I resent being forced into those kinds of choices, because I didn't think that it made sense for Oklahoma. It really made more sense for us to have six, because our state falls into six geographical areas. So what I've tried to do is to create a system which will give fair representation to every area of the state, the Northeast, Northwest, Southeast, and Southwest quadrants, and then the Oklahoma City and Tulsa metropolitan areas. A great variation in problems exists between rural and urban areas as far as medical services are concerned, and I felt that this was the fairest way to get input. Our state board has been put together representing a very wide cross section of people in the field of health services, both those who are providers and consumers of health services from all parts of the state. But it is certainly a very strong intent that we not build another bureaucracy. I want to leave a great deal of autonomy to those

in health planning and in the six regions that we're creating. I think that these six regions make sense when you look at the state of Oklahoma geographically. Really, I suppose you could say what we're really trying to create in Oklahoma is six HSA's, not one or three but six with some general coordination. We're taking coordination being accomplished by people who represent those six areas, and we're still putting major reliance upon the health planners who have been serving at the regional and local level in the past. We're not trying to build a whole new bureaucracy here at the state level, because I'm certainly opposed to that. I think you would have problems if you tried to throw, let's say Oklahoma City and the large rural areas of the state into one HSA, or Tulsa and one large rural area into one HSA, or if you tried to throw Oklahoma City and Tulsa into one together. Three HSA's just didn't fit our state very well. We have really four major rural areas of the state and two major metropolitan areas, and it seems to me that it makes much more sense to do it that way.

Q. Governor, most of the problems and most of the situations we have discussed today involve the federal government in one way or another. What do you consider the federal government's role in health care?

A. I think its role should be as minimal as possible, and I have very strong feelings about it. I think that many of the regulations which they write are just like utilization review, and I have talked with some people who have admitted that they didn't even consider the problems that U.R. might cause in small community hospitals. They don't have very many small community hospitals in Washington D.C., and many of those people don't know what they're dealing with. If we're going to solve the problems we face, and this is true not just in the medical area but all areas, I think we have to tap the creative abilities and resources of our individual people. You can't do it from Washington. Washington is now becoming calcified with bureaucratic top-heaviness. We've got to leave some room for creative experimentation to solve problems. It's like the experimentation we're trying to carry out in Oklahoma toward solving the welfare problem and reducing the welfare roles. We have reduced the welfare roles by 5,000 people this year.



Just as soon as we try to experiment it seems that someone from Washington comes along and does something like impose the day-care regulations on us which will do nothing but triple the cost of day-care to working mothers and force a lot of people back into welfare again. It's self-defeating! I think if we're going to defeat the problems we have, we need to get Washington more and more out of our affairs and allow people at the state and local level a chance to try different approaches toward tough social and financial problems. For one thing, we just cannot afford continual growth of the federal government.

When they say they have to regulate more and more, they have to grow more and more. We just cannot stand it. I heard it said the other day that it took us 186 years to get to the first one hundred billion dollar federal budget, and it took us nine more years to get to two hundred billion, four more years to get to three hundred billion, and one more year to get to barely under four hundred billion. This cannot go on. I think it's really helping to increase the cost of medical care, and it's crippling the energy industry at a time when we need to be doubling and tripling our investment in order to find new sources of supply. It's almost as if they deliberately set out to cause crises in the country and to test how well we at the local level can get around the federal regulations and still solve our problems. So I have very, very strong feelings about it. I think that state governments and especially the private sector, have much more expertise than the people in the federal government think we have, and problem solving should be left up to the people at those levels. □

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NHI Hearings Completed—Begin Again

After nearly a month of discussions, the House Ways and Means Health Subcommittee has closed its hearings on national health insurance, shifting the attention to the House Commerce Health Subcommittee which commenced similar hearings in early December. Both committees claim jurisdiction in the matter of NHI and have scheduled separate hearings.

During the last session of Congress (93rd), more than a dozen health insurance bills were introduced, many of which were reintroduced before the current Congress. In principle, they all seek to make health care available to all persons, but each proposal differs in its effect on the economy and on the nation's health care system. Generally, testimony before the House Ways and Means Health Subcommittee has been devoted to four or five bills which have received the most widespread support. They include the AMA backed bill, a similar bill endorsed by the AHA, the Kennedy-Corman bill, the HIAA plan, and a catastrophic insurance plan by Senators Long and Ribicoff. Each differs in its method of financing and the type of coverage offered.

Of the many plans introduced before Congress, most would continue and expand the concept of health care furnished through employee group insurance. This type of plan would minimize the need for government financing and additional taxes since most persons would be covered through an employee-employer arrangement. Under this plan, coverage would also be available to the unemployed, the self-employed, and those unable to meet the cost of health care insurance. Comprehensive coverage would be tied in with the program, with the government sharing the cost through general revenue funds and without special taxes.

The AMA and AHA sponsored plans (H.R. 6222 and H.R.1 respectively) are employment-based plans which require the employer to provide insurance for his employees. While employment oriented, the current HIAA plan (H.R. 5900) departs from the principle of required employer-participation. Under the plan, however, if the coverage provided by the employer does not meet the requirements built into the bill, the employer stands to lose the income tax deductions for premiums.

The Long-Ribicoff bill (S. 2513) would provide a different type of insurance coverage, including benefits for catastrophic occurrences only. Benefits would begin after certain health care expenses were met by the individual or family. The individual or family could purchase insurance to meet basic health care expenses. The costs of the program would be paid through social security taxes and the benefits would be administered by the Social Security Administration.

The Kennedy-Corman bill (S. 3, H.R. 21) would introduce a different concept in the health care system. It would establish a national health service with provisions similar to the British system. Health care would be provided within a fixed national budget annually established by the federal government. Funds for the program would be created through new social security taxes levied on payroll, wages, and self-employment income for one-half of the cost. General revenue funds would pay the rest.

During the month-long hearings, labor leaders, medical leaders, and other interested persons appeared before the subcommittee to support the bill of their choice and to oppose others. Generally, testimony seemed to split down occupational lines, with labor leaders backing one bill (the Kennedy-Corman measure) and medical leaders speaking in support of either the AMA bill or the AHA bill.

At the hearing's first session, Leonard Woodcock, UAW President and Chairman of the Health Security Action Council, insisted that only Labor's bill could "shore up our collapsing health care delivery system." Woodcock made it clear to the subcommittee that Labor would make no significant compromises. AFL-CIO President George Meany also spoke in favor of H.R. 21, the Kennedy-Corman bill. Meany told the group, "The delivery of medical services is a monopoly of the medical profession, and it should be dealt with as a monopoly. That is, if medical costs are to be controlled, the medical monopoly must be confronted with a counter-vailing force."

Alfred Baker Lewis, representing the NAACP and the Connecticut Health Security

Council, told the subcommittee that free hospital and medical care is a right of the people. He supported the Labor endorsed bill.

A host of speakers appeared before the subcommittee to support the AMA and AHA endorsed bills. R. Lowell Campbell, President of the Association of American Physicians and Surgeons, said it would be a tragedy to repeat the mistake made when Congress passed the Medicare-Medicaid law on the basis of misrepresentations and falsehoods by the federal bureaucracy. He said, "Compulsory politicalized medicine—which is deceitfully labeled National Health Insurance — is a big-spending idea whose time has come and gone."

Although a spokesman for the U.S. Chamber of Commerce did not endorse a specific bill, he did warn of the dangers of federal subsidization of health care costs. He told the group that "because NHI is so potentially inflationary, and because insurance is not an acute problem for the great majority, an insurance plan should be modest or postponed until a really effective cost control strategy is agreed on."

The AMA was represented before the subcommittee by its President, Max H. Parrott, MD, and by its President-elect, Richard E. Palmer, MD. Doctor Parrott urged support of AMA's bill, H.R. 6222, the Comprehensive Health Care Insurance Act of 1975. "When considering a national plan for this country, it is necessary to take cognizance of the strengths of our own method of health care delivery," said Doctor Parrott. "This will assure that our excellent system will continue to improve and will not suffer the stifling effects experienced in other countries."

The two AMA witnesses characterized the medical profession's national health insurance plan as building on the structure of the present system of employee-employer group health insurance plans. Under the plan, they explained, each employer would be required to make available comprehensive basic and catastrophic benefit coverage. The employer would be required to pay 65 per cent of the cost of the plan.

Doctor Palmer warned the subcommittee, "We cannot afford to have a program of such importance fail! We must avoid the mistake inherent in proposals such as H.R. 21 (Kennedy-Corman) which would lock medicine into a rigid, monolithic, no choice bureaucratic system. Such a creation would be impossible to

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reverse. It would be an undertaking full of promise but empty of fulfillment." He further warned that "establishment of cost control through fixed budgets including arbitrary fee schedules would result in curtailment of care and discourage participation by providers."

The AMA witnesses observed that 135 million Americans under 65 carried major medical insurance in 1974. "This is the most rapidly growing form of health insurance in the nation, and the trend for such added coverage is fostered by an increasing public awareness. Consequently, we must question the need to impose on the American taxpayer and consumer a costly universal federal program of freestanding catastrophic insurance."

The AMA spokesmen also pointed out the changing attitude of the American public with regard to the importance of enacting a national health insurance program. They said, "Our national priorities have also shifted because of the effects of the changing economy, and the devastating effects of inflation on all segments of our society. The public has expressed among its major priorities a concern with inflation, with the state of the economy, and with crime."

Doctor Parrott concluded by telling the subcommittee, "There is fuller realization and acknowledgment that this country's health system — under attack by many in the course of the NHI debate — is indeed superior to any other in the world." □

OSMA Pension Program Accepting Enrollees

OSMA members can now enroll in an association-sponsored retirement plan which over the years should save them administrative, legal and other fees and insure them of one of the best, custom-designed plans available. The plan was authorized by the Board of Trustees on recommendation of the Council on Insurance.

The OSMA program offers Oklahoma physicians a convenient and reliable plan for setting aside tax-deferred dollars for their future retirement needs. A centralized management team oversees the plan's operation, resulting in substantial savings in administrative costs, trustee fees, legal fees, actuarial services and accounting services. Trained plan consultants have designed a comprehensive program and will personally present it to member physicians with no obligation.

Work on the OSMA retirement program began as a result of a survey of Oklahoma doctors which showed that 65 per cent wanted their association to enter into the pension field. The OSMA spent six months investigating and putting together the program which is unique to most others. It became operational around the first of the year.

Under the program, self-employed doctors may enroll in a Keogh-type plan and set aside up to $7,500 a year without paying current income tax on that portion of their earnings. Incorporated physicians can enroll in either a profit-sharing or a corporate-type tax-sheltered program. Those doctors may set aside an even larger portion of their income in the tax-deferred plan.

Some of the most respected names in the business are taking part in making the program work. The First National Bank and Trust Company of Oklahoma City serves as Trustee of the program. All funds that are contributed for investment are placed into two pooled trusts, a Fixed Yield Trust and an Equity Trust, thus giving a small clinic many of the advantages before available only to large clinics with many employees. The First National Bank maintains a general ledger on the Trust as a whole and supplementary ledgers for each participating organization. The total fund is appraised monthly and participating physicians and their employees will receive annual written accounts.

Another name most doctors will recognize is the Massachusetts Mutual Life Insurance Company which underwrites the insurance portion of the program. The Oklahoma City Massachusetts Mutual General Agency is one of the top agencies in the country and personnel were hired especially for handling the OSMA pension plan.

Additionally, the OSMA Qualified Plan Service Company has been formed to guarantee continuity of service for the retirement plan. The company will be exclusively devoted to the design, administration and servicing of individually tailored retirement plans for participating physicians. An OSMA Pension Committee has been formed to act on changes in the plan which may become necessary in the future and to assist in the administration of the program. The committee is made up of the Chairman of the Council on Insurance, the Executive Director, and one other selected physician.

OSMA members wanting additional information about the plan may contact the OSMA

Qualified Plan Service Company, 1480 First National Center, 120 Park Avenue, Oklahoma City, Oklahoma 73102. Or, they may call (405) 232-2717. □

No Miracle in Weight Loss

The Better Business Bureau of Central Oklahoma has been receiving a number of requests for information about the Professional Reducing Centers of Oklahoma City, Inc., a firm which started operations here in September, 1975, and is headquartered in Wichita, Kansas. It offers a controversial weight loss program which consists of daily injections of HCG (Human Chorionic Gonadotropin), a hormone prepared from the urine of pregnant women, and a 500 calorie a day diet. Warnings have been issued by the Federal Trade Commission which issued complaints against five west coast operators and news bulletins have been released by the Food and Drug Administration and American Medical Association.

The plan offered, costs $55 for the physical examination and $20 weekly for injections which may run 12 weeks and then be repeated. The cost may run as much as $700. A release by the Food and Drug Administration states: "HCG has not been demonstrated to be effective adjunctive therapy in the treatment of obesity. There is no substantial evidence that it increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or "normal" distribution of fat, or that it decreases the hunger and discomfort associated with calorie-restricted diets. The FDA emphasizes strongly that any active drug may have unexpected adverse reactions. In the case of HCG, there is not even a scientifically plausible rationale to explain how it could influence bodily fat distribution and the sense of hunger and discomfort that results from dieting, as has been claimed."

HCG is a hormone which has its most important use in stimulating ovulation, thus permitting pregnancy in certain infertile women.

The Food and Drug Administration has announced that it intends to require producers of this hormone, which is used by "fat clinics" such as the above, to say that there is no evidence the drug is useful in the treatment of obesity. □

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40th International Medical Assembly Slated to Meet in San Antonio, Texas

San Antonio will again play host to the International Medical Assembly of Southwest Texas. The 40th Annual Meeting will be held in San Antonio's St. Anthony Hotel and The University of Texas Medical School at San Antonio, Thursday and Friday, February 26th and 27th, 1976.

San Antonio, one of America's four unique cities, and once considered to have a climate so healthful and harmless that the people could get along very well without a doctor, will welcome about 600 physicians and their families from throughout the United States and Mexico.

This year, the program is dedicated to the American Academy of Family Physicians, with built-in interest for the specialist. Nine outstanding guest speakers have been obtained, along with panels composed of local experts from The University of Texas Medical School at San Antonio, Wilford Hall Medical Center, Brooke Army Medical Center and the Bexar County Medical Society. Opportunities for questions and disussion from the floor will be provided. Application for prescribed credit by the American Academy of Family Physicians has been made.

There will be social functions for the wives and physicians, including a cocktail party with music by the High Society Band, consisting of physician-musicians. A golf tournament is scheduled for Saturday. At the conclusion of the two-day convention, the Annual Extension trip will be to Madrid and Costa del Sol, Spain. This trip has become an integral part of the postgraduate medical seminar and the number of physicians and their wives going on the trip has increased every year.

The distinguished speakers for the 40th International Medical Assembly are:

Family Practice — Carl B. Hall, MD, Charleston, West Virginia

Cardiology — Robert S. Eliot, MD, Omaha, Nebraska

Internal Medicine — Maxwell L. Gelfand, MD, New York, New York

Internal Medicine — Robert W. Ryder, MD, Atlanta, Georgia

(Continued on Page 32)

Obstetrics—Gynecology — Carl Pauerstein, MD, San Antonio, Texas

Orthopedic Surgery — Richard Bryan, MD, Rochester, Minnesota

Psychiatry — Thomas P. Hackett, MD, Boston, Massachusetts

Cardiovascular Surgery — Denton Cooley, MD, Houston, Texas

Colon and Rectal Surgery — Stanley Goldberg, MD, Minneapolis, Minnesota

Those interested in receiving further information or registering may write to: Mr. S. E. Cockrell, Jr., Executive Director, 202 West French Place, P.O. Box 12678, San Antonio, Texas 78212. □

Course in Anesthesiology Planned

A course in anesthesiology for non-specialists will be offered April 5th-9th by the University of Oklahoma College of Medicine. The course is designed for physicians who are not specialists in anesthesiology but whose practice includes the administration of anesthetics.

The four-day course will be divided into morning and afternoon sessions, with the mornings dedicated to a one teacher one student experience in the operating room and the afternoons devoted to demonstrations and discussions.

Registrations are now being accepted with applications selected primarily on a first-come, first-served basis. The registration fee is $150, and the deadline for all applications is March 10th.

Faculty from the OU College of Medicine's anesthesiology department will serve as faculty for the course. Participants are eligible for 40 credit hours in Category I of the AMA's Physicians Recognition Award.

Topics for this year's course in general anesthesiology include:

Airway Management

Resuscitation and Tracheal Intubation

Intravenous Supplements to General Anesthesia

Pediatric Anesthesiology

Management of Problems in Obstetric Anesthesia

Regional Anesthesia

Local Anesthetic Agents

Postoperative Management of Anesthetic Complications

Preanesthetic Evaluation of The Surgical Patient

Intraoperative Management of Fluids and Electrolytes

For additional information about the course write: Office of Continuing Medical Education for Physicians, University of Oklahoma College of Medicine, 121 MS, P.O. Box 26901, Oklahoma City, Oklahoma 73190. □

University Offers Course on Sodium, Potassium, Water and Diuretics

The University of Oklahoma College of medicine will offer a continuing medical education course on "Sodium, Potassium, Water and the Diuretics" on March 17th, 1976.

This is the seventh consecutive year that a program dealing with renal urinary tract disease and fluid and electrolyte disturbances will be presented. Emphasis this year will be on the evaluation and management of clinical problems related to sodium, potassium and water excesses and deficits and the role of diuretics in management of edematous states.

A guest internist, pediatrician and urologist will be joined by a number of local faculty in discussing current concepts and recommendations in a series of formal presentations. These presentations will be followed by open discussions.

Simultaneous sessions will be held for the Allied Health Professionals (nurses, dialysis technicians, dietitians, social workers and other interest personnel) oriented toward transplantation and its role in the management of the patient with end stage renal disease.

The sixth annual Paul Kimmelstiel Memorial Lecture will close the meetings for both groups.

Featured speakers will be: Robert W. Schrier, MD, Professor and Head of the Division of Renal Disease, University of Colorado Medical Center, Denver, and Kenneth N. Walton, MD, Louise McDonald Orr Professor of Surgery, and Chairman of the Department of Urology, Emory University, Atlanta, Georgia.

Additional information is available from the Office of Continuing Medical Education for Physicians, University of Oklahoma College of Medicine, Room 121 MS, P.O. Box 26901, Oklahoma City, Oklahoma 73190. □

Health Education

To become more involved in helping meet the health needs in our communities is one of the goals of medical auxiliary. The health education committee seeks to give inspiration and incentive in this area. As the name suggests, the area is as broad (or as narrow) as the individual county auxiliary wants to interpret it. The local auxiliary recognizes a need, then seeks to be instrumental in meeting that need. Thus we can help to improve the quality of life in our community, particularly in the field of health services.

Throughout the state, the activities are many and varied. Several auxiliaries give scholarships to high school seniors choosing a health career, while others award them to college students. Health Career Clubs are sponsored by local auxiliaries at the high school level. Other activities range from sponsoring Candy-Stripers to recognizing the best health-related research project with a cash award in science fair competition. A newer approach to encouraging young people to become interested in health careers is in explorer groups. Several of these groups are under sponsorship of county medical societies, some with auxiliary help, while others are being sponsored by health-care facilities. These groups are generating a great deal of interest and enthusiasm at the high school level. They offer a broad over-view of the many facets of health careers with a good personal contact with medical personnel and health-care facilities. Some of the more ambitious groups have made quite extensive field trips.

The Oklahoma legislature has given emphasis to health education in Oklahoma public schools. A new "Comprehensive Compulsory Health Education Curriculum Guide" was distributed last spring. This program is being implemented on the local level throughout the state. This means that more specific health education will be taking place in Oklahoma schools. This is viewed as a phase of preventive health education. Ideally, the populace will be educated to make the right choices as to personal health care, thus practicing individualized preventive health programs. Some auxiliaries are providing help in this area as resource people in the classroom. Auxiliary members serve on school advisory committees throughout the state, while several serve as school board members in their communities. One auxiliary provided textbook material (in comic book and coloring book form) on an elementary level. Others are providing materials made available by the Oklahoma Council for Health Careers for distribution to interested student groups.

This year, we are co-operating with Community Health Committees in immunization emphasis, and preventive health-care programs such as V-D education, adolescent nutritional needs, and early disease detection. Whenever possible, the auxiliary health education committee seeks to complement and co-operate with the similar committee in the county medical society.

We like to take a positive view about what we do! In the past year alone, auxiliaries across the country participated in 71 nutrition programs, 105 child abuse programs, 155 drug abuse programs, 136 immunization programs, 144 blood donor programs, 95 safety programs, 57 parenting programs, and 138 screening programs. Multiply these figures in terms of PEOPLE HELPED to get a better idea of what we accomplish working together for a common cause. We see health education as a positive approach to health-care needs. *Sue Medcalf,* OSMA Auxiliary Health Education Chairman

REMEMBER — NATIONAL RURAL HEALTH WEEK — APRIL 4th, 1976

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LUFYLLIN® (dyphylline)

Before prescribing, please review complete product information, a summary of which follows:

Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Precautions: Exercise caution with use in the presence of severe cardiac disease, renal or hepatic malfunction, glaucoma, hyperthyroidism, peptic ulcer, and concomitant use of other xanthine-containing formulations or other CNS stimulating drugs.

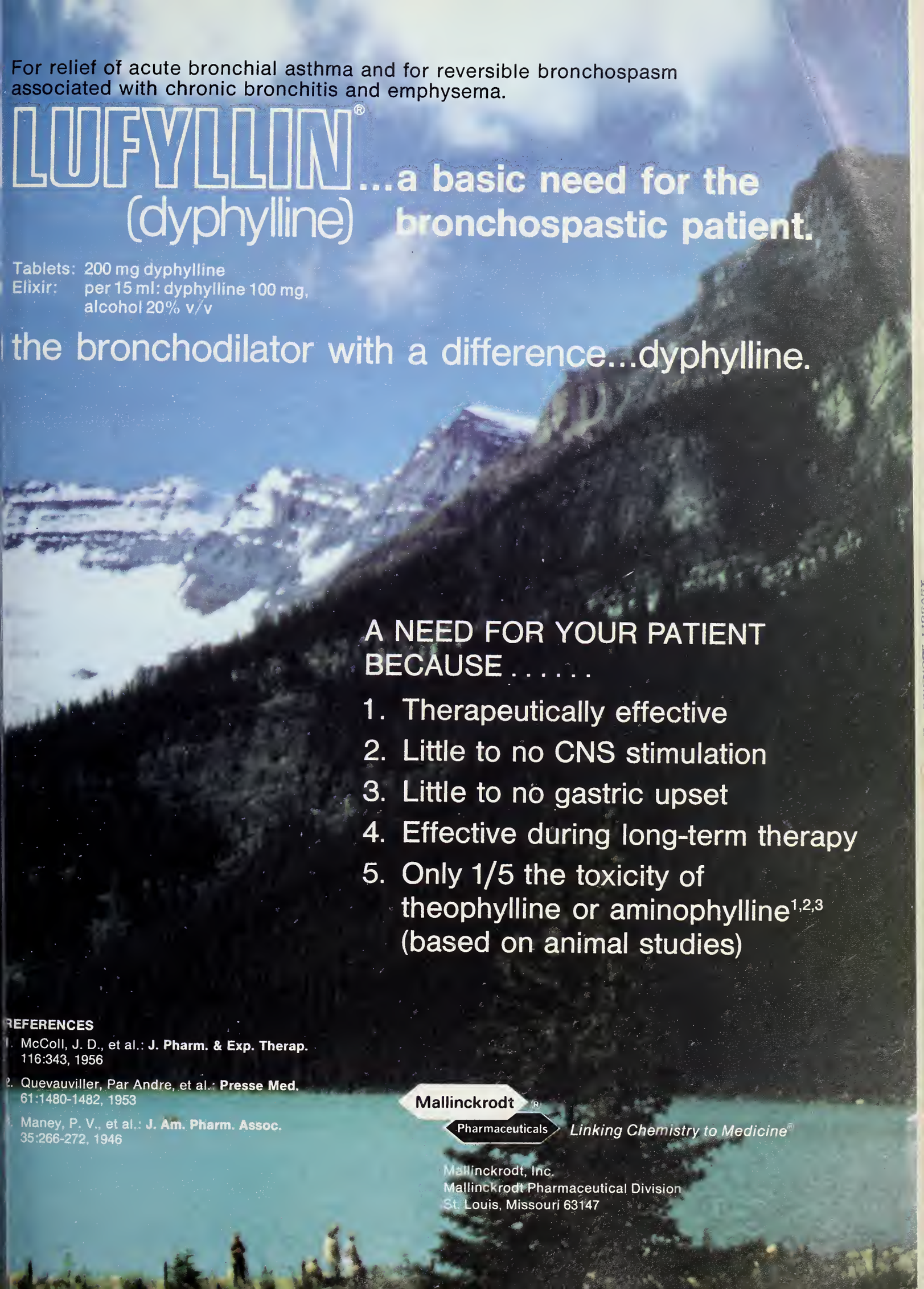
Adverse Reactions: May cause nausea, headache, cardiac palpitation and CNS stimulation. Postprandial administration may help to avoid gastric discomfort.

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LUFYLLIN, 200 mg., Tablets: NDC 19-R521, bottle of 100; NDC 19-R521-97, bottle of 1000.

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...a basic need for the bronchospastic patient.
Tablets: 200 mg dyphylline
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5. Only 1/5 the toxicity of theophylline or aminophylline[1,2,3] (based on animal studies)
REFERENCES
1. McColl, J. D., et al.: J. Pharm. & Exp. Therap. 116:343, 1956
2. Quevauviller, Par Andre, et al.: Presse Med. 61:1480-1482, 1953
3. Maney, P. V., et al.: J. Am. Pharm. Assoc. 35:266-272, 1946
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Quote the Assistant Secretary of HEW: Many doctors consider HEW Assistant Secretary Theodore Cooper, MD, a refreshing change from some of the federal bureaucrats who have held that and similar positions at HEW. He has gained the respect of many physicians through his honest approach. His remarks at the AMA's Intern and Resident Business Session in Atlantic City last summer earned him even more respect.

"The reliance on federal control of the health care system will lead to a rigidity and a dehumanization of the practice of medicine that would make the right to health care — even if that goal were finally achieved — a hollow and bitter prize for everyone."

"There are two paths away from this dilemma, and I believe that we in the health field have to lead the way along both of them: firstly, the whole American health enterprise — public, private, voluntary — will simply have to take the initiative in identifying major issues and problems and pursuing meaningful courses of action aimed at problem-solving. One of the challenges that faces the medical profession is to wrest leadership away from government. And I can assure you so long as that leadership is responsible, anticipatory, and effective, this government would much prefer to see it exercised by the private health sector. Secondly, we should be frank with the American people, with their lawmakers and with ourselves. We have fostered the fiction that abundant, readily available high-quality health care would be some kind of panacea for the ills of society and the individual. Thus, we have fueled exaggerated expectations from the public."

"The federal government cannot effectively manage the health care system of this country. I hope that job is never given to us."

A strange thing happened recently — someone voted to reduce their rates. An almost unheard of occurrence took place recently at a meeting of the Oklahoma Board of Medical Examiners — the Board voted to reduce renewal fees from last year's $15 to $12 in 1976. Board Secretary E. W. Young, Jr., MD, said the reduction was possible because of "increased efficiency of our operations this year in spite of the fact that we had more applications for licensure and more renewals to process." Doctor Young said the board would mail applications for renewal in April, and he advised that if any doctor did not receive the form by the first of May, he should contact the board. The law requires that renewals be received by June 10th.

In California, up to 45 per cent of the physicians may either retire, modify their practice, or leave the state after January 1st, 1976, says a report in the MLC COMMENTARY. This will take place, says the report, unless something is done to relieve physicians from spiraling medical liability insurance rates prior to the first of the year. The information was released by the California Medical Association and was based on data collected by local and county medical societies and hospital staffs. Other physicians in California have indicated that they will refuse to renew their insurance policies next year. Joseph F. Boyle, MD, Speaker of the CMA House of Delegates, said at least ten per cent of California's medical professionals have already retired or left the state, and that another ten per cent are expected to do so soon. Premium rates were expected to increase by 341 per cent in Northern California in November, 1975, while physicians in Southern California expected increases of up to 486 per cent as of January 1st.

"Thru" is through at the CHICAGO TRIBUNE. The newspaper has virtually surrendered in its fight, initiated in 1934, to correct an "unspeakable offense to common sense" by simplifying the spelling of 80 words. It has abandoned such spellings as "thru," "tho" and "thoro" because they have not caught, or is it "kot," on. The paper will, however, retain the "og" words like catalog and epilog on the ground that they seem to be gaining in acceptance. "Sanity some day may come to spelling," the *Tribune* said in an editorial recently, "but we do not want to make any more trouble between Johnny and his teacher." It comes as welcome news to writers also, who have enough trouble without any additional confusion. □

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(Cover Art By William Cason)

Internal Medicine Review Course

1976

Every Thursday—

5:00 P.M. to 6:30 P.M.

EAST LECTURE HALL

Basic Science Education Building

University of Oklahoma

College of Medicine

Oklahoma City, Oklahoma

Coordinator: Dale Groom, MD

SECOND SEMESTER SCHEDULE

DATE — TITLE — SPEAKER

February 19th, 1976—Renal II—Acid Base Disturbances and Therapy, Chris Kaufman, MD, Robert D. Lindeman, MD

February 26th, 1976—Renal III—Urinary Tract Infection, Stone Formation, Anthony Czerwinski, MD

March 4th, 1976—Renal IV—Acute and Chronic Renal Failure, Etiology and Management, J. A. Pederson, MD, Anil K. Mandal, MD

March 11th, 1976—Infectious Disease I, John Mohr, MD

March 18th, 1976—Infectious Disease II, Hanna Saa'dah, MD

March 25th, 1976—Gastroenterology I, Gastroenterology Section

April 1st, 1976—Gastroenterology II, Gastroenterology Section

April 8th, 1976—Current Concepts of Hematology, Walter H. Whitcomb, MD

April 15th, 1976—Congenital Heart Disease in the Adult, Lotfy L. Basta, MD

April 22nd, 1976—Valvular Heart Disease, Eliot Schechter, MD

April 29, 1976—Metabolic Disorders Presenting in the Adults, Sylvia Bottomley, MD

May 6, 1976—Pituitary; Adrenal; Endocrine Hypertension, John R. Higgins, MD

May 13, 1976—Hypertension, Edward D. Frohlich, MD

May 20, 1976—Thyroids and Gonads, David C. Kem, MD

May 27, 1976—Nuclear Medicine for the Internist, E. William Allen, MD

This continuing medical education activity is acceptable for 1½ hours per session in Category I for the Physician's Recognition Award of the American Medical Association and for the American Academy of Family Physicians.

Send registration and/or request for further information to: Office of Continuing Medical Education for Physicians, Univerity of Oklahoma College of Medicine, Room 121MS, P.O. Box 26901, Oklahoma City, Oklahoma 73190. Attention of: Irwin H. Brown, MD, Director

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

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HAIL SUCCESS

She was 108 years old.

She had been the ideal patient. Did everything her doctors advised her to do. Well, almost everything.

Although she was already elderly by the time we all started worrying about cholesterol, she worried along with us. She loved butter and milk and cheese and cream gravy, but she eliminated them from her diet and worried about her cholesterol. And about ten years later, she heard about triglycerides and quit using sugar and quit eating biscuits and jelly and gave up drinking the glass of wine she enjoyed so much before her evening meal. She worried about her triglyceride levels and, because of her sacrificed calories, she grew quite thin. This pleased her doctors. Her sacrificed pleasure did not please her, but she managed an occasional smile.

In her later years her smiles were almost rare and sometimes wincing. Her arthritis caused a great deal of pain especially on the damp, chilly days. She quit taking aspirin many years ago even though it had afforded almost complete relief. She heard that aspirin could cause stomach ulcers, kidney problems and bleeding tendencies. The other arthritis medicines were even more dangerous than aspirin, so she avoided all of them. She suffered much of the time.

Ever since she quit taking hormones years ago, because she heard they caused cancer, her bones ached a lot, too. Especially at night. And she had chilly sensations and spells of depression and lots of trouble sleeping, which probably accounted for her extreme fatigue. Also she seemed much more fragile because she broke bones nearly every time she stumbled and fell. Of course that interfered with her exercises which she did vigorously, every day, as her doctors had advised. She was forced to be inactive and this worried her.

Most of her days were occupied with reading and watching TV. Her favorite articles and programs were those that dealt with health and medical subjects even though they seemed to upset her. Some days she refused to eat anything that was red or salted or canned. It seemed the more she read and the more she watched TV, the more she worried.

She took great pride in her exceptional willpower, and the fact that she had outlived five doctors and thirty-eight relatives. Every year, on her birthday, the people at the nursing home baked a cake for her and honored her as the first and the oldest resident of the home. Her great grandchildren used to come to those parties but they moved away sixteen years ago.

Her life could be a testimonial for prudent living. She had done everything she had been advised to do, except for one thing. She simply couldn't stop worrying. Everyone thinks this is what finally caused the deterioration of her mental faculties twelve years ago, and, eventually, her death.

Her antiquity proved the wisdom of her ways. At the simple graveside services it was quite apparent that she had outlived all her friends and family. A minister who lamented the fact that he had been a stranger to her on each of his weekly visits, and an undertaker who seemed anxious to conclude the ceremonies were the only people there.

She had succeeded where most of us fail.

MRJ

Are You A Candidate For A Lawsuit in 1976?



The Professional Liability Insurance for physicians has become a problem nationwide, Yes, even in Oklahoma! The basic professional liability insurance cost in Oklahoma increased almost 50% starting January 1st, 1976, while the umbrella liability insurance premium increased about 350%. The basic insurance is carried by Insurance Company of North America, and the umbrella insurance is carried by C.N.A. (Continental National American).

Even at the rate increases that we have sustained, we still have the best and most economical liability insurance in America. Our Professional Liability Insurance Study Commission is continuing to work, and to explore avenues that will improve our liability insurance problem. Our Legislative Committee is working diligently to improve our problem by Legislative reform. They have caused several new bills to be introduced into the current legislative session, with special emphasis on our omnibus bill . . . Senate Bill 622. That is where our membership becomes all important. If every member of our OSMA will support this legislation, it will not fail. Please call your own legislators today and ask them to support this important cause.

The time when the issue of insurance cost becomes important is when we sign our check to go to the insurance company. It is with regret that check signing time is one of the few times that we can get the interest and attention of many of our members. How great our accomplishments could be if we had this kind of interest in all areas of organized medicine.

Our increased insurance cost is not a reflection of losses in Oklahoma, but it is reflective of the impact of a national trend toward escalation of insurance losses. There are, however, many more malpractice lawsuits being filed in Oklahoma than ever before. With the increase in the number of malpractice actions filed, we must find ways to prevent the lawsuits from occurring. I will list only a few:

1. Practice good medicine. In doing so, we will be forced to order more diagnostic procedures.
2. Keep up to date by continuing postgraduate education.
3. Avoid loose talk, both the physician and his staff. Never criticize your fellow physicians, or it will come back to haunt you.
4. If you do see a problem created by one of your colleagues, try to correct it without talk or fanfare. It will be appreciated by all concerned.
5. Avoid the problem patient when possible.
6. Spend extra time with your patients, talk to them and let them know that you are their friend.
7. Keep good medical records, and never change a hospital record.
8. Get consent forms signed by the patient and sign the form yourself.
9. Make a note in the medical record that you have explained the following. a. Nature of treatment. b. Possible complications. c. A statement that the patient indeed does understand.
10. Watch loose talk when in conference with a lawyer.
11. It is important to have complete cooperation between you and your own legal counsel in the event a lawsuit does arise.

In spite of all of the preventive measures, we will continue to have lawsuits filed. So long as medicine and surgery are practiced by human beings, there will always be a possibility of error. The best possible continuing education program will not eliminate all mistakes, because no physician is perfect; we all, however, can improve ourselves.

I have been delighted this year with the united effort that all of our OSMA members have put forth. Once again, I call for a continued united effort from our membership, to assist in passing the long needed medical liability legislation. Urge your legislators to enact S.B. 622 into law!

OSMA JOURNAL / scientific

Essential Tremor: A Common and Treatable Disorder

DAVID A. DAVIS, BS
D. L. LANDSTROM, MD
NGUYEN-NHUT THONG, MD

Recent advances in the treatment of this surprisingly common and often disabling disorder have added new importance to its recognition.

Essential or familial tremor is a disorder whose fairly frequent occurrence is not generally appreciated. Surveys have shown it to be approximately as common as its more familiar counterpart, Parkinson's Disease — the condition with which it is most often confused. Both occur in the general population at an incidence of about 1 in 1,000.[4]

In recent years, more effective but differing means of treating these two disorders have appeared. This fact makes their accurate differentiation of more than academic interest and adds increased importance to the old clinical saw, "All that shakes is not Parkinson's Disease."

CLINICAL FEATURES

Essential tremor is usually inherited in an autosomal dominant fashion with varying rates of expression. In this situation it goes under the rubric of hereditary, heredofamilial or familial tremor. It is occasionally seen in individuals without an appropriate family history.[1]

The age of onset varies considerably and it thus has often been divided into infantile, juvenile, adult and senile types. It is more than likely, however, that these types all represent the same basic condition.[2]

Tremor is the sole clinical manifestation of the disorder. It usually begins in the upper extremities and frequently remains limited to them although it may, in occasional cases, affect any body part including the head, eyelids, lips, tongue, jaw and lower extremities. Involvement of the laryngeal muscles bestows a tremulous quality to the speech and, when severe, can render it virtually unintelligible.

The tremor is of the same frequency as, and has been considered by some to be an exaggerated form of, physiological tremor. It is the amplitude, the coarseness, of the tremor which causes embarrassment and disability for the patient — this combined with the fact that it occurs mainly during voluntary action. While the tremor of Parkinsonism is present at rest

and usually improves with voluntary movement, the opposite is true of essential tremor which is rarely observed at rest but which appears with voluntary posturing or movement. Hence it can be much more disruptive of normal activity than Parkinsonian tremor. At times, it may have a quality of terminal accentuation characteristic of so-called intention tremor. Early in its course, it may be apparent with only occasional short bursts of higher amplitude interspersed in the normal low amplitude of physiological tremor. It often eventually progresses, becoming of continuously high amplitude. Its pathology is not understood.

An intriguing feature of essential or familial tremor is its responsiveness, in many cases, to a modest amount of alcohol. One or two drinks are often sufficient to completely but transiently suppress the abnormal movements. The social consequences of such dramatic effects of alcohol can readily be imagined. Because their "shakes" are so obviously relieved after a drink or two, such individuals are commonly falsely maligned as alcoholics. Unfortunately many such patients do come to rely on alcohol for suppression of their tremor — particularly in social or work situations in which it is aggravated by pressure and anxiety — and eventually find themselves addicted.

DIFFERENTIAL DIAGNOSIS

As previously noted, the most common differentiation to be made is from Parkinson's Disease. Ordinarily this should not be difficult. The differences between the tremors usually associated with the two conditions have been described. While the patient with essential tremor will have no other neurologic findings upon examination, the Parkinsonian patient should display additional stigmata of his disease such as paucity of movement and of facial expression, decreased frequency of blinking, characteristic posture and gait, "cogwheel" or "lead pipe" rigidity and loss of postural reflexes.

Other conditions productive of tremor which might figure in the differential diagnosis include thyrotoxicosis, chronic alcohol usage, Wilson's Disease and intoxications with drugs such as the phenothiazines, diphenylhydantoin and lithium.

A family history of similarly tremulous relatives can be immensely helpful.

PROGNOSIS AND TREATMENT

Some patients experience little increase in the amplitude of their tremor and no progression to other body parts throughout life; for them it poses little or no handicap. In others, however, the amplitude of the tremor insidiously increases over a decade or more to the point where the patient is no longer able to perform such simple daily activities as writing or raising a glass to the mouth. Employability may be seriously impaired and embarrassment can lead to a constricted social life.

Essential tremor has generally proven unresponsive to treatment with barbiturates, anticholinergic agents, major and minor tranquilizers and L-dopa.[4,5]

In recent years, therapeutic success has been reported with the use of propranolol, a beta adrenergic blocking agent.[3,6,7] Propranolol diminishes the amplitude of the tremor but has no effect upon its frequency. It is most effective in suppressing tremor of the hands and of less noticeable benefit for tremor of the head, neck or voice. The optimal daily dosage averages 120 mg/day in three or four divided doses but

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A 1966 graduate of the University of Illinois College of Medicine. D. L. Landstrom, MD, is currently Associate Professor of Neurology at the University of Oklahoma College of Medicine. He is a member of the American Academy of Neurology and the American Electroencephalographic Society.

Since his graduation from Saigon Medical School in 1964, Nguyen Nhut Thong, MD, has limited his practice to his specialty, neurology. He is currently a senior resident in neurology at the University of Oklahoma Health Sciences Center. He is affiliated with the World Federation of Neurology.

quantities as small as 10 mg tid or qid can often be effective. Unlike alcohol which has a rapid onset of action, propranolol requires one to two days and sometimes longer for its effect and must therefore be used chronically.[7] It must be used with caution in patients with congestive heart failure, partial or complete heart block, sinus bradycardia, asthma or allergies, chronic obstructive lung disease and diabetes mellitus.

In one study, 83% of patients felt clearly improved with propranolol. Patient satisfaction was related to relief of disability rather than to complete freedom from tremor, since the drug suppresses the amplitude but does not abolish the tremor.[7] As mentioned, the best results from propranolol can be expected in regard to tremor of the hands with less response from other involved body parts. Precautions concerning the use and discontinuance of propranolol must be observed.

SUMMARY

Essential or familial tremor is a relatively common neurologic disorder the true incidence of which is probably considerably underestimated. Its recognition has become of greater practical value with the introduction, in recent years, of more effective therapy. Its clinical characteristics are outlined and differential diagnosis from other common disorders productive of tremor, particularly Parkinson's Disease is discussed. Treatment of the disorder with propranolol is also described. □

REFERENCES

1. Fahn, S.: Differential Diagnosis of Tremors. Med. Clinics of N. Amer., **56:** 1363-1375, 1972.
2. Marshall, J.: Tremor, in Vinken, P. J. and Bruyn, G. W. (eds.): Handbook of Clinical Neurology, vol. 6. Amsterdam, North Holland Publishers, 1968, pp. 809-825.
3. Pakkenbert, H.: Propranolol in Essential Tremor. Lancet, 1: 633, 1972.
4. Swift, I.: A Comparison of Propranolol and Benzhexol in Essential Tremor. Practitioner, **213:** 91-96, 1974.
5. Sweet, R., et al: Propranolol Treatment of Essential Tremor. Neurol. (Minneapolis), **24:** 64-67, 1974.
6. Winkler, G. F. and Young, R. R.: The Control of Essential Tremor by Propranolol. Trans. Amer. Neurol. Assoc., **96:** 66-68, 1971.
7. Winkler, G. F. and Young, R. R.: Efficacy of Chronic Propranolol Therapy in Action Tremors of the Familial, Senile, or Essential Varieties. New England J. Med., **290:** 984-988, 1974.

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RECENT ADVANCES IN NEPHROLOGY

April 12th-14th, 1976 **Galveston, Texas**

The American College of Physicians (ACP) will sponsor a three-day postgraduate course entitled "Recent Advances in Nephrology" on April 12th-14th, 1976, in Glaveston, Texas. The course will be held in conjunction with the University of Texas Medical Branch.

Purpose of the meeting is to give specialists in internal medicine and related fields an opportunity to review basic information and to find out what is new in a particular area of interest.

The course is designed to cover current status of commonly encountered disorders of the kidney as well as related diseases. It will provide a comprehensive and integrated review for internists and nephrologists, emphasizing advances in pathogenesis, diagnosis and management. The role of the kidney in hypertension will be studied.

The course has been approved by the American Medical Association's Advisory Committee on Continuing Medical Education and may be used to fulfill Category 1 requirements for the AMA Physicians' Recognition Award.

Further information may be obtained by writing the Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

OSMA JOURNAL / special

Health Systems Agencies — Just Another Hurdle?

GEORGE W. PROTHRO, MD, MPH
IRA H. SCHLEZINGER, BS, MPA

Will federally mandated Health Systems Agencies result in more efficiency in health planning and coordination or present just another barrier? This paper concerns problems envisioned.

"Hurdle" may be defined on the one hand as an obstacle — on the other as the act of mastering a difficulty or problem. Will Health Systems Agency as prescribed in the National Health Planning and Resources Development Act of 1974 be just another barrier for the health administrator to overcome or will it result in a new level of efficiency in health planning and coordination, benefiting not only the health administrator, but more importantly, all of us who are recipients of health services? Can a Health Systems Agency (HSA) actually create a system out of the present health non-system? The ultimate answer to these questions depends not only upon the content of Public Law 93-641 and the regulations to be developed thereunder, but upon the dedication of Congress, the administration, and local and State agencies in carrying out their commitments under the law. Only time will tell.

The purpose of this presentation is to review real, perceived or potential barriers which the HSA may create. Only HSA's as an element of the Legislation will be reviewed.

Public Law 93-641 is unique in many ways. The Act has been described as a legislative nightmare born out of two years of compromise during the helter-skelter last days of the 93rd Congress, at the same time, having the potential of being the most far-reaching bit of health legislation since the enactment of Medicare. Very few federal laws have attempted to go into the detail spelled out in this legislation. Does the inclusion of these details, usually left to regulations, imply an intent of Congress to keep a tight rein on the planning and development of health resources and services, or is it a subtle slap at the administration and its powers to mold policy through regulation.

A problem which surfaced immediately and which apparently was not envisioned by the draftors of the legislation is the decision by the Governors of over 25% of the states, including the State of Oklahoma, to maintain central control of the HSA planning process through designation of single health service areas. Admittedly a number of the states had to be single HSAs because of population criteria, but the majority did not. By designating the entire state as a single service area and then, in the

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case of Oklahoma and perhaps others, specifying the creation of sub-area advisory councils within the state, the governors have attempted to pacify the demand for local input. Governors have thus utilized one of the shortest and most non-specific subsections in the law—Section 1512(c), to effectively circumvent the intent that Health Systems Agencies be regional in scope.

The governor's proposal for Oklahoma designated the state as a single HSA with six sub-area councils. Planning is proceeding on the basis that each of these sub-areas will have staff capacity to carry out the planning functions of that sub-area. Even though the level of federal funding for Oklahoma might be adequate to staff the office of a single HSA, it is questionable whether this same staff would be adequate to perform significant planning or coordination functions if diluted by distribution throughout six sub-areas as well as an HSA core office. The matter is further complicated by the fact that there are absolutely no criteria in the law for the designation of sub-areas. The geographic sub-areas being proposed may make no more sense than the fact that the entire state is considered a single Health Systems Area.

Hurdles in implementation of the HSA to serve many designated areas are already evident, and other hurdles will unquestionably surface.

Implementation of regulations developed but unapproved and undoubtedly to be challenged, will create further problems. An immediate issue relates to the difficulty in carrying out an orderly transition between existing planning operations, the Comprehensive Health Planning (CHP), Regional Medical Programs (RMP), and Hill-Burton programs, and the new Health Systems Agencies. The law calls for phasing out of existing entities by January, 1976. It now appears that most will be phased out by July, 1976. Yet, the proposed regulations call for an articulation of community need as part of the HSA application process. Existing planning agencies have performed this mission in the past, and will of necessity need to be a point of departure.

CHP agencies in many parts of the country were just gaining momentum, efficiency, and community acceptance. Over a period of seven or eight years, an organizational structure had been established, staffing had been obtained, functional procedures had been developed, and in general, the agencies were attaining proficiency in their role. What happens to this momentum as we now shift gears into another planning and development system? More importantly, what happens to the program priorities these agencies encouraged the provider sector to pursue? Compounding the problem of transition is a recognition that although procedures for submitting applications for approval of proposed HSAs have been prepared, no mechanism has been defined for approving one HSA applicant in the event multiple applications are received for a single area.

The preamble to the regulations in and of itself raises the issue of administrative intent. Public Law 93-641 was permissive on the issue of public HSAs, yet the regulations throw in the concept of a "governing board" with major control over the "governing body." The HSA Board, for all practical purposes, is defined as a "governing body." The governing board which can be regional planning bodies, or a single unit of general local government, would have the authority to:

—Select and remove members of the separate governing body for health planning;

—Establish personnel policies and review the appointment of the executive director and staff;

—Establish, execute, and revise the agency's budget;

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—Set rules and regulations for the functioning of the agency;

—Review and comment on any proposed action on the separate governing body.

It would seem that the regulations have exceeded the intent of the legislation and may be in conflict with the statute itself.

Once off the ground, the HSA will have responsibility for review and comment, in some instances, and for review and approval or disapproval in others. The time schedule for implementation of this HSA activity will necessitate conducting reviews without adequate time for developing the HSA's own criteria for making decisions. There may well be a reluctance to accept controversial guidelines and criteria established by previous agencies. The health administrator, who has just acquired some expertise in dealing with the intricacies of the present review system, is now faced with the possibility of an entirely new, and at present, unspecified methodology of review.

Just as P.L. 93-641 does not appear to provide a mechanism for harnessing and utilizing the momentum and benefits of existing planning entities, neither does it provide a mechanism for correcting problems which may have become evident in the existing system. There have been charges that the Boards of CHP agencies and RMPs have not been accountable to the public. If this be true, then the new law appears to provide few, if any, additional conditions for assuring public accountability.

A practical barrier to the HSA being able to carry out its assigned responsibilities is money. Even the most liberal discussions in Congress relating to levels of appropriation to fund HSA's are considerably below the amounts authorized in the law. Compounding the problem has been the little (if any) Congressional commitment to funding the Area Health Services Development Funds. This fund is the source from which the HSA will eventually make grants to public and nonprofit private entities to assist them in planning and developing projects and programs which the HSA determines are necessary to achieve the health systems goals described in its Health Systems Plan. Thus, the big "carrot" which the HSA had to offer health entities in its area is, to date, being ignored in Congress.

National health priorities were established in Section 1502 of the law. The HEW Secretary must define national health planning goals related to these priorities. The HSA in developing its Health Systems Plan must be consistent with these national guidelines. The HSA may, as a result, place undue emphasis on national priorities and goals even though these, in whole or in part, may not be pertinent to the area in question. Thus, a law which theoretically is designed to implement effective planning at the local level has the potentiality of subjugating local needs to national priorities. Effective local planning then becomes secondary to conformance with national goals.

The health administrator who may have had occasion in the past to complain of detailed reporting, auditing, and monitoring of health program activities by the "federal partner" will now find himself in an entirely new and even more complex role of accountability. Obviously, accountability is desirable and necessary under this new law. Unfortunately, the concept of accountability now has the potentiality of becoming so detailed that reporting becomes of primary importance and program activity and services become secondary. For example: One of the national health priorities under the law is, "The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improve management procedures for health services institutions." Cost accounting is necessary and has been too long neglected. However, every health administrator knows that health programs cannot be funded or compared solely on the basis of comparative costs of providing services. In consideration of competing applications for funding, an HSA might give undue consideration to these cost comparisons. Obviously this does not take into account other significant factors, not the least of which is the quality of the service provided.

Down the road, HSA will be subject to detailed review, at least every three years, by the Secretary of HEW. Among the items to be considered in such a review (Section 1535) is the appropriateness of the data assembled, the status of the health resources and services of the area, and the extent to which it may be demonstrated that the health of the residents in the agency's health service area has been improved. How is this to be determined? The Secretary is to specify the minimum data necessary to determine the health status of the residents of the area and the status and utilization of health resources and services. It is obvious that compulsory data reporting systems

which may or may not be relevant to individual agencies and their functions will be required. Public and institutional health officials have long been concerned with the problem involved in documenting benefits of preventive programs. The health provider previously faced with the difficult, if not impossible, task of developing valid performance indicators for evaluating the results of specific health programs may now have performance indicators developed and imposed upon him.

One should also keep in mind the add-on potential of the legislation. When the law that created CHP and RMP agencies was enacted in 1966, it contained only limited control measures. Since passage, however, Certificate of Need laws have been enacted in 22 states, which along with Section 1122 of the Social Security Amendments, have been tied back to CHP agencies for review and comment and in some instances review and approval. This, coupled with an increasing number of federal categoric grant programs requiring review, has given existing areawide planning agencies real clout. Public Law 93-641 has the same add-on potential in such areas as recertification, rate review, and licensure.

CONCLUSION

Will these and other hurdles unforeseen at this time, be merely obstacles in the path of the health administration, or will they result in the attainment of the congressionally envisioned new level of planning, coordination, and efficient delivery of health services? We must recognize that many health administrators have been "turned off" to being involved in ambitious national planning endeavors as a direct result of ineffectual or unresponsive planning; negative review and comment experiences; polarization along consumer-provider lines; questionable local, state and federal expectations; marginal appropriations; and continual federal intervention into what was perceived to be a local or state pursuit. Yet these interests are, and will continue to be the backbone required for implementation. The months to come should prove most interesting. We can only hope that they prove to be a step of genuine progress rather than a plunge into chaos. □

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Opportunities and Issues In New Health Planning Legislation

CHARLES M. CAMERON JR., MD

Public Law 93-641 is the third attempt to introduce planning in the US Health Care System since the 1960's. Identification of strengths and weaknesses from past and present efforts may be the key to essential involvement of physicians.

Public law 93-641 — The National Health Planning and Resources Development Act of 1974 — represents the culmination of over 125 years of effort in the United States to utilize the planning approach in seeking solutions to the problems of health and medical care delivery.

The first comprehensive health plan was developed about 1850 in Massachusetts and since that time comprehensive plans have been devised to deal with problems of medical education, health manpower, health facilities, public health services, mental health services and a host of other pressing issues confronting both providers and consumers of health care.[1]

Public law 93-641 is the third generation of efforts on the part of the Federal government since 1960 to stimulate the development of health planning at the state and areawide levels. The first efforts in the 1960's resulted in the development of approximately 60 hospital planning councils in major metropolitan areas of the United States. The second generation effort was embodied in P.L. 89-749, the "Partnership For Health Act," which resulted in the development of state health planning agencies in all the states and approximately 250 areawide health planning organizations. Public law 93-641 is anticipated to strengthen and consolidate some of the progress made under P.L. 89-749 and when fully implemented will provide support for approximately 200 health systems agencies charged with responsibility for health planning and resources development at the local level.

Prior to identification of opportunities, problems and issues inherent in the new legislation, it is useful to review the experiences, both good and bad, recorded in the two previous Federally sponsored planning efforts to determine, if possible, useful lessons which may be of value as groups set out to implement the new legislation.

HOSPITAL PLANNING COUNCILS

The prototype of the hospital planning council was developed in 1938 in New York City when the Hospital Council of Greater New York City was formed as a body to guide the orderly development of a system of institutions in that major metropolitan area.[2] In the years that followed, several other major American

cities followed New York City's example since there was evidence that the presence of such an organization provided for a degree of coordination among capital fund drives, resulted in better balance in the development of an overall hospital system and provided a forum for the hospital interests of the community to interact with one another and with various outside groups.

In 1946 the report of the Commission on Hospital Care was published which indicated that during the war years the nation's hospitals had reached a sad state of neglect and that many communities were without any hospital service. In calling attention to the need for an infusion of funds to build and modernize hospitals, the commission also proposed that hospital development in each community should be guided by a hospital planning council.[3]

That same year saw the enactment of P.L. 79-725 (better known as the Hill-Burton Act) which provided for federal, state, and local support of hospital construction. It was not until 1961, however, that a later amendment provided federal funds for the support of hospital planning organizations. Between 1961 and 1966 when the comprehensive health planning legislation was enacted, approximately 60 such organizations were developed.[4]

Reviewing this experience retrospectively, what can be said of the hospital planning council legacy to health planning in the United States? Most important to recognize is the almost exclusive concern of these organizations for in-patient care, an obviously important dimension of medical services, but a type of care which on any given day provides care to less than one million of the nation's over 200 million residents. Over the course of a single year, the hospital touches only between 10 and 15 percent of the total population. Experience seems to have taught the painful lesson that utilization of services depends more on the kinds of facilities and services available than on the health service needs of the population. Said another way, hospital beds appear to generate the use of hospital beds. If hospitals were not so costly to construct and operate, it is unlikely that their utilization as a site for care, needed or not, would be a matter of any concern, but the last few years have shown clearly that the hospital is the single most expensive site for the delivery of health services. In hind-sight, it seems evident that if hospital councils had devoted attention to the health service needs of the population and had promoted a balanced range of health services, they might have stimulated the growth of other patterns of care which in turn could have impacted upon third party reimbursement arrangements, medical education, and a host of other prominent features in the current medical care scene.

The hospital councils lacked perspective as to what their true function was in the community. If they had seen their primary task as stimulating the development of health services rather than promoting the construction of hospital beds, some of the present day concern about over-building of beds might have been avoided. Their missed opportunity for diversification and expansion into new fields should stand as a major lesson for the new Health Systems Agencies.

One explanation for the actions of hospital councils perhaps can be found in the make-up of their councils. They, by and large, were drawn from the leadership of the medical and hospital community who saw their tasks as promoting more and better utilization of the hospitals, both existing and planned, in their communities. The lesson here suggests that health council membership should draw upon the full range of interests and specialties in the health field and not those heavily committed to any single interest or practice.

In many instances when the hospital planning council felt that additional construction was not warranted, they were unable to receive support for their findings since they were dependent in large measure on voluntary persuasion and education as their major mechanisms for implementation of their recommendations.

Overall, considerable pride can be taken in the accomplishments of the pioneering organizations in the field of health planning. Their overall success lead to the conviction that the planning approach should be extended to include all health services, health manpower and other institutions. It was this conviction that lead to the enactment of the comprehensive health planning legislation in 1966.

COMPREHENSIVE HEALTH PLANNING

It was the intent of P.L. 89-749 to continue the locally based, voluntarily oriented planning body, but to broaden its focus to all health concerns and to open the decision-making process to consumers of health services represen-

tative of the population characteristics of the area.

Those who have attempted to evaluate how well consumers have been assimilated into the CHP organizations have noted only partial success. Upper middle class consumers have been present and have played an important role in many CHP councils, but all too often the racial, economic, and geographic minorities apparently have not found a place to interact with health professionals, government officials and other members of boards, councils, and committees.[5]

Any assessment of the experience of comprehensive health planning agencies during the past nine years would not be complete without considering the extent to which these organizations have been successful in achieving implementation of their plans and recommendations. Such an evaluation is difficult since many agencies are only now producing their first area health plan and only in the past two to three years have CHP agencies been particularly active in Section 1122 and other types of project reviews. While the record is spotty across the country, overall it has been noted that many agencies have approved the overwhelming majority of all projects submitted to them for review and where disapproval has been voted, their recommendations have been ignored or set aside in the face of pressure from other interests.[6]

Complete objectivity requires that it be pointed out that much of the fault as to the unclear program functions and mandate to CHP organizations rests with the inconsistent leadership provided by the federal government and not to a lack of vision or ability at the state and local levels. The 89th Congress which established comprehesive health planning, also gave birth to the Regional Medical Program, Experimental Health Systems Projects, neighborhood health centers and a number of other related programs all with vague and overlapping responsibilities. This situation was only partially remedied in 1973 when Agency Performance Standards and Criteria for CHP agencies were developed and a system of nation-wide agency assessments and agency improvement efforts were initiated. Although expectations and responsibilities were clarified by this process, in many instances CHP agencies still have fallen short of the high hopes evident when the legislation was first introduced.

In retrospect again, one may say that these planning organizations given a monumental task to accomplish were given a pitifully small amount of resources to accomplish the job. While in the Bible, giants are slain with slingshots, it rarely happens in modern day America. It has been said that the seeds of failure were germinated in CHP in terms of an indistinctly defined role and mission, an inadequate budget and staff to deal with the complexities of the health care system, and no "clout" with which to achieve any degree of implementation of plans and recommendations.

That these lessons were apparent to many is evidenced by many of the features of the new health planning legislation.

PUBLIC LAW 93-641

The new legislation attempts to build on the strengths of CHP while adding new dimensions which relieve to a degree some of the problems faced during the past several years.[7]

The new legislation carries forward the partnership concept involving the various levels of interaction at the federal, state, and local levels, but has added a significant new dimension at the national level where there will be National Guidelines for Health Planning and a national health policy. These national health goals and standards will be developed by a National Health Policy Council, a body which has been notably absent in past health planning and resource development efforts. At the national level in the past, the federal agency administering health planning activities did not have any policy guidance and

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was a grant management operation funneling dollars to the state and local levels. Through the new legislation, there is an opportunity for the development of a policy focus at the national level, an ingredient missing from the national scene.

At the state level, a state agency will be continued although it will have a new name, "The State Health Planning and Development Agency." It will be closely linked with, or actually incorporate, other organizations engaged in resources development such as the Hill-Burton agency, the Regional Medical program and others. In many states this may clear up the conflict between the health planning and hospital construction agencies which in some instances have found themselves on opposite sides on project review questions as well as actual and potential conflicts with the Regional Medical program.

The state council will be continued, again with a new title, "The State Health Coordinating Council." This council will be composed of providers and consumers, but the majority of its membership must come from individuals nominated by the local health systems agency (the new title of the areawide health planning organization.) This requirement should bring the state and local points of view on needs and priorities much closer together than in the past. Also required is a state certificate of need law which should strengthen the implementation capabilities of the organization.

At the local level, the health systems agency will serve an area identified as a health service area. Health service areas generally will be larger than the areas served by comprehensive health planning organizations. It was the intent to enlarge the jurisdictions to include larger areas more representative of patterns of health care delivery and a broader range of health resources. The decision in Oklahoma to designate the entire state as a health service area will bear careful study as to whether such a large area mitigates against the essentially local orientation of the agency which many feel is essential.

In contrast to P.L. 89-749 which was vague as to the exact responsibilities of a health planning agency, P.L. 93-641 is very specific in terms of functions and activities of a health systems agency. The primary responsibility, however, is effective planning and development of health services, health manpower, and health facilities within the designated health service area.

To facilitate orderly planning, the agency is called upon to collect and analyze a wide variety of data about health status and the health care system of the area and to utilize this and other information in the preparation of two health plans: *the health systems plan* which is to be a goal-oriented plan providing long range guidance to the development of the local health care system and *the annual implementation plan* which will identify specific targets for immediate action during a particular year.

To assist in gaining support for its recommendations and in stimulating the development of resources, the agency is expected to continue broad representation on its council by medical groups, government officials and consumer groups. Even more localized involvement is provided for thorough provision for sub-area councils.

Implementation will not stop at participation, however, since the agency will have a fund of developmental dollars which can be awarded to initiate the priority projects identified in its annual implementation plan. The new act also strengthens the review authority vested in the local agency and gives it authority to impact upon state and federal decisions with regard to facility construction, service projects and other actions which are now taken outside of the local area.

While many would see these refinements in P.L. 93-641, what problems are beginning to emerge as state and local groups move toward implementation throughout the nation?

POTENTIAL PROBLEMS

1. One of the greatest potential problems already evident in the implementation of the new legislation is the likelihood that in some states and local areas much time and effort will be wasted because of the failure to recognize and utilize the leadership potential represented by the health professionals, community leaders and others who have been active in the development and guidance of comprehensive health planning over the past several years. These individuals represent a cadre of leadership which should be mobilized in the development of health systems agencies and state health planning and development agencies. In most places it will not be necessary to reinvent the health planning wheel.

2. A second concern centers about the fact that although the Regional Medical Program was scheduled to be phased out and the developmental functions of RMP incorporated in the new structure of health planning agencies, the RMP organizations seem to have a remarkable longevity. Further, one of the major responsibilities assigned to RMP during their phase-out period is the lending of support to the formation of health systems agencies and other components of P.L. 93-641. In view of the dedication of some RMP staff members to preserving the present independent status of their organizations and of their sponsored projects, there remains a significant question concerning how much real assistance the health planning agencies will receive. The assignment of transitional monies to the state health planning agency for allocation among the potential health system agency applicants would appear as a more rational alternative.

3. A third potential problem concerns the level of financing available in the future to support the activities now funded through comprehensive health planning, the Regional Medical program, and the state Hill-Burton programs. Although all these three functions are to be incorporated into a single structure, the preliminary estimates of total funds to be available represents only a fraction of what is now appropriated for the three programs.

At the level of the health systems agency, minimal financing of the program of activities was estimated to cost about 50 cents per person per year. Best current estimates indicate that the administration's budgetary request may result in only about 30 cents per capita being available. The chronic underfunding of previous health planning activities has been shown to be a major deterrent to progress. One hopes this mistake will not be repeated.

4. A fourth potential problem revolves around the needs of health systems agencies and state health planning and development agencies for technical assistance and consultation in the development of the new structures and new activities mandated by the law. A major source of such assistance should be the regional offices of the Department of Health, Education and Welfare which also have suffered from shortages of skilled personnel in the past. There is no indication that major additions are contemplated to aid the states and communities in the next few months when such resources may be essential.

5. A last concern focuses on the mechanisms which the federal government has employed in the development of the regulations which will spell out the details of actual operations of the new planning programs. For some months, word has leaked from the federal level in Washington that such regulations are being developed and, more recently, were in draft form. That no representatives of local and state health planning agencies have been privileged to review these documents prior to their actual publication appears as a major lapse on the part of the federal government and raises significant questions concerning the nature of the partnership which is envisioned among the three levels of activity. Those who must be actually involved in the implementation of the law should be given a major role in the formulation of the ground rules.

NEW OPPORTUNITIES

So much for possible problems. What can be identified in the way of new opportunities and incentives in the legislation?

First, P.L. 93-641 is an opportunity to maintain and extend the significant work of comprehensive health planning agencies at the state and local levels. Further, it can maintain the best of the Regional Medical Program activities and continue some federal support in the modernization and construction of needed health facilities. The health planning activities which may have faltered in the past can be carried on with new incentives, additional fiscal resources and the increased authority which the law gives health planning agencies. Those medical groups and others who have complained of the impotence of health planning in the past will find new arrows in the quiver of implementation.

Secondly, again there will be an opportunity of demonstrating that significant state and local problems do not have to be passed to the federal level for meaningful solutions. Health planning energetically and successfully conducted at the state and local levels remains one of the best bulwarks against complete federal domination of the nation's health care system.

Third, the legislation, if successfully implemented, can stake out a strong role for state and local groups in future developments in the health care field. Since national health insur-

ance appears inevitable, the demonstration of administrative and planning competence within the states may serve as a buffer against the complete centralization of authority at the national level.

Lastly, the legislation represents a continuing opportunity for demonstrating the viable and essential nature of the involvement of physicians, community leaders, and citizens in developing health services which serve the needs and expectations of both providers and consumers.

ATTAINING THESE OPPORTUNITIES

Obviously, this is no time for the existing individual and organizational leadership in health planning to rest on the oars. Existing health planning agencies should work toward completion of health plans, continue careful reviews of health projects referred to them, and continue their efforts toward bringing together the multiple interests which characterize the American health care system. All those in CHP, RMP, and related agencies who aspire to have a stake in the new HSA structure must get their houses in order.

It is hoped that the medical profession will continue as active participants in the formulation and activities of the new structure. Other than complete dedication to making the new system work will be an open invitation for other groups to lay claim to the leadership roles in the field of community health.

SUMMARY

New health planning legislation — P.L. 93-641 — has been identified as the third generation of health planning activities in the United States since 1960 although examples of health planning go back as far as 125 years ago.

Hospital planning councils and comprehensive health planning agencies have been identified as the precursors of the new structure of health systems agencies. In recognition of problems associated with previous planning efforts, the new legislation provides greater authority and incentives for the implementation of plans at the area and state levels.

Despite the attempts to minimize problems in the legislation, already a number of potential problems relating to funding, transitional authorities, needed technical assistance, and the development of regulations have been identified.

Although certain improvements have been made in the legislation, realization of the potential will rest with the vision, energy, and dedication of those who are involved in the implementing actions. Physicians are urged to maintain and expand their commitment to and involvement in health planning at the state and community levels. □

References

1. Hanlon, John J.: *Public Health Administration and Practice.* C. V. Mosby Company, St. Louis, Mo. Sixth Edition, 1974.

2. Peters, J. P.: "Background and Legislative History of Comprehensive Health Planning." *Tulane Home Study Course on Comprehensive Health Planning.* Tulane University School of Public Health and Tropical Medicine, New Orleans, La., 1975.

3. Bergwell, David F., Reeves, Philip N. Reeves, and Woodside, Nina: *Introduction to Health Planning.* Information Resources Press., Washington, D.C., 1973.

4. Wisowaty, Kenneth W., Edward, Charles C. and White, Raymond L.: "Health Facilities Planning." *JAMA,* Vol. 190, No. 8, November 23, 1964. pp. 752-756.

5. O'Conner, John T.: "Comprehensive Health Planning: Dreams and Realities." *Milbank Memorial Fund Quarterly-Health and Society.* Fall 1974. pp. 391-413.

6. _____: "Comprehensive Health Planning As Carried Out by State and Areawide Agencies in Three States." A report to Congress by the Comptroller General of the United States. (Report B-164031(2)) April 1974. Processed. 88 pages.

7. _____: "Health Planning & Resources Development Act of 1974. Department of Health, Education and Welfare Publication No. (HRA) 75-14015. Superintendent of Documents, U.S. Government Printing office. 1975. 20 pages.

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The Guidance Center Program of the Maternal and Child Health Service of the Oklahoma State Department of Health is now composed of fifty-two (52) centers serving forty-six (46) counties. Guidance Centers are an integral part of County Health Departments and under the medical direction of the physician in charge of the local health department. The philosophy of the community guidance center program revolves around prevention, early detection, and remediation of emotional, social, speech, language, developmental, and learning problems in children, adolescents, and families. Early detection and treatment of problems can help youth to become more stable adults, which enables them to be better parents.

Most therapy in the Guidance Centers is short term and usually includes counseling with both the child and his parents. In addition to individual therapy, the centers engage in family therapy and marital counseling.

The larger Guidance Centers are staffed with psychologists; social workers; speech pathologists; child development specialists; public health nurses; and, pediatric, audiologic, otolaryngologic and psychiatric consultants. Patients are charged on a sliding

scale fee, but no one is denied service because of inability to pay.

Guidance Center staff provides consultation and education to teachers, case workers, physicians, Head Start programs, day care centers, judges, probation counselors, and the public in general, to increase their knowledge and understanding of children.

Guidance Centers sponsor Otolaryngology Clinics in Shawnee, Lawton, Muskogee, Stillwater, and Ada. The Otolaryngology Clinics provide for a preliminary examination and treatment of children and adults suspected of having ear, nose and throat pathologies for which immediate medical attention is indicated.

An Early Childhood Development Program is another component of the Guidance Centers. This program is primarily designed to increase the child-rearing competencies of parents through parent education. Child development specialists are now working in many guidance centers. Others will be added as funds become available. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR DECEMBER, 1975

DISEASE	December 1975	December 1974	November 1975	Total To Date 1975	Total To Date 1974
Amebiasis	1	1	1	32	29
Brucellosis	3	1	—	6	13
Chickenpox	157	3	159	1351	1167
Encephalitis, Infectious	—	—	3	57	58
Gonorrhea (Use Form ODH-228)	1228	1113	982	13278	11508
Hepatitis, A, B, Unspecified	66	9	87	832	999
Leptospirosis	—	—	—	—	2
Malaria	—	—	—	2	6
Meningococcal Infections	1	1	3	14	19
Meningitis, Aseptic	9	—	2	87	65
Mumps	53	1	82	348	417
Rabies in Animals	7	1	4	108	165
Rheumatic Fever	—	—	2	10	12
Rocky Mountain Spotted Fever	3	—	—	89	70
Rubella	9	—	6	103	66
Rubella, Congenital Syndrome	—	—	1	2	1
Rubeola	124	—	4	270	30
Salmonellosis	19	3	23	268	268
Shigellosis	39	9	15	336	191
Syphilis, Infectious (Use Form ODH-228)	8	21	6	94	154
Tetanus	—	—	—	—	3
Tuberculosis, New Active	26	1	28	311	284
Tularemia	—	—	—	9	18
Typhoid Fever	2	—	—	3	2
Whooping Cough	3	1	1	28	20

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An Interview With Medical Liability Defense Attorney, George F. Short

By Richard L. Hess
OSMA Director of Communications

JOURNAL: A great deal of time and effort went into surveying legislation in other states and in deciding what was applicable to the medical liability situation in Oklahoma. Can you explain the overall concept and purpose of the OSMA endorsed professional liability bill?

SHORT: We evaluated their legislation in terms of their problems and our problems and decided that basically, at this point in time, we didn't want to change the system. Therefore, our legislative thrust is based on first creating legislation or a program that will preserve the insurance market in Oklahoma. In other words, something that will not only show the current carrier but other carriers that we are interested in preserving a climate in which they can afford from the standpoint of the market place to insure the physicians of Oklahoma. Secondly, our thrust is based on the idea that there are inequities in the laws in this state in terms of defense in this type lawsuit and so we want to introduce legislation which will hopefully offset these inequities and make it easier to defend a medical malpractice suit or professional negligence lawsuit. Thirdly, our thrust is designed to convince the legislature and private citizens in Oklahoma that we are interested in doing something to take care of, from the standpoint of discipline, the rare physician, who commits malpractice. We want to be able to re-educate and rehabilitate him because the public has an investment in him, and we also want to keep his acts from affecting all of the good physicians in this state. So we actually have three thrusts in mind.

JOURNAL: Does this mean we are not interested in bringing about the type of sweeping change which is being advocated in several states with bigger problems?

SHORT: In terms of as it exists presently, yes. If three years from now we are faced with the crisis that exists in other states, we might have to have other solutions. But we are not prepared at the moment to abandon the system. This is what is occurring in the states that have a real crisis. They're preparing to shuck the system, but I think the system works well in most places. There's nothing inherently wrong with the system.

JOURNAL: The OSMA professional liability program started out as five or six separate bills and eventually was condensed into one omnibus piece of legislation. Is there any particular advantage to this?

SHORT: We put it in one package primarily at the request of the state administration, the Governor's office, in order to make it easier for the Governor to follow the bill and to give it his support. It will be much easier for him to keep track of one bill rather than five or six. This way the Governor can support one as well as can anyone else who wishes to support our program. We introduced one bill with that in mind in order to make it easier for our supporters to get behind it.

JOURNAL: Will the fact that it is one bill in any way compromise its chances of being approved?

SHORT: I suppose in the eyes of some it

might, but overall I should think not because the bill is designed to meet various facets of an overall problem. Really, we think from the standpoint of justice and equity and in dealing with the problem it's difficult for me, not only as a lawyer but as a man of logic and as a person interested in the problem, to think that anyone who is cognizant of the problems involved could oppose the entire bill. Frankly, I can't see how packaging the sections under one bill number would make it any more vulnerable to attack than if we had introduced it through various authors.

JOURNAL: If the bill is passed, what will be its overall effect on the professional liability problems in Oklahoma?

SHORT: Well, it's not going to make the problem go away in terms of whatever motivates the public currently, but it will have several beneficial effects. It will have an effect on the insurance market, and it will have an effect on clarifying fuzzy areas of the law. So it will straighten out some of the confusion. It will make, therefore, the defense of these cases easier in the sense of clarifying the problems. It will be of benefit; there may be some plaintiff lawyers who can't decide whether they have a lawsuit or not or can't decide to take a case or not. With the benefit of this bill, legitimate lawsuits will be easier to recognize. So there is



". . . we are not prepared at the moment to abandon the system."

that aspect of it. We didn't introduce the bill with the idea of taking away from any truly injured patient the right to sue his doctor.

JOURNAL: Since each section of the bill deals with a different problem, I would like to take a section by section approach in describing its specific purposes. The first section, which I believe has been referred to informally as the "good faith" section, provides for a better method of professional introspection. It also provides that examining boards and leaders of the Legislature will receive more detailed information pertaining to medical malpractice claims and the disposition of these claims. Could you elaborate on this section?

SHORT: Section 1 of the bill is the section dealing with the reporting of claims and lawsuits to the central agency of the state, and there are several reasons for this. First, I think it should be pointed out as a matter of dealing with the problem that when we have gone to the Legislature and urged the Legislature to take action in terms of assisting us with legislation, we have fortunately met with somewhat of a friendly ear. But invariably, members of the Legislature say, "Well, you're only dealing with one aspect of the problem. We'd like to see you also deal with the problem of the assumption that there may be a need for tighter controls on the allegedly negligent doctor." The Legislature says they have no source, no information other than what the OSMA tells them and what the insurance carriers tell them in terms of the frequency of the claims, the seriousness of the claims, and the nature of the claims. Nor do they have any way of knowing who are the offenders in terms of defining them by category so that they necessarily look with a jaundiced eye upon the claims of the insurance carriers in terms of what's going on. In spite of the fact that two sessions ago the OSMA sponsored and the Legislature enacted the so called Sick Doctor Amendment to the medical practice act, the Legislature insisted that something be done in this area. Section 1 of the bill is an attempt to deal with that. It requires that the burden of reporting claims be placed upon the liability insurer. This was done by preference; we didn't particularly want to place the burden of reporting claims on our physician-members. This suggests that the burden of reporting should be placed on the liability insurer whenever a claim is made and within 60 days of the time of the inception of the claim. A report should be made to the



"We didn't introduce the bill with the idea of taking away from any truly injured patient the right to sue his doctor."

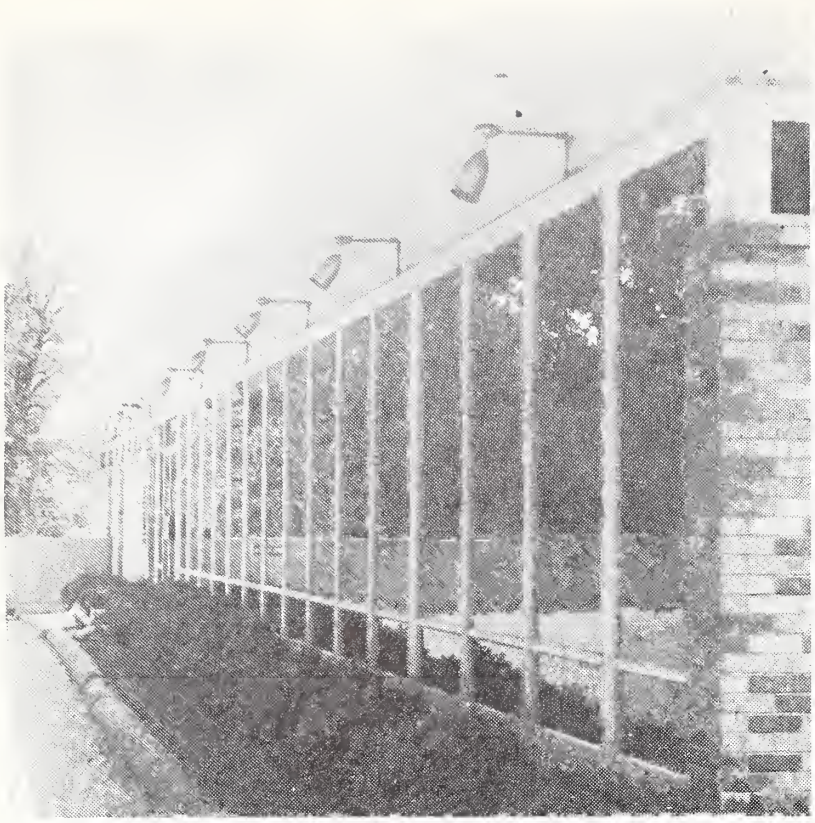
Board of Medical Examiners or the licensing board of each particular group licensed under the healing arts. The reports should contain the name and address of the practitioner and the hospital involved; the name, agent, address of the claimant; a brief statement about the nature of the injury or the illness or the condition complained of; whether a suit is pending; and if so, in what court the suit is pending, the style of the case, and the docket number. When the lawsuit is concluded the type of disposition and the nature of the disposition and the amount of the money paid shall be reported to the appropriate board or agency. The section also provides that these reports shall be exclusively for the use of the agency and confidential. Frankly, it seems to us that this type of bill meets several needs. It provides the Legislature with information in terms of the insurance crisis. It provides the particular board or agency with additional information and power to deal with the "incompetent practitioner," and we think it is a bill that really provides a great deal of aid and comfort, not only to the physician who is practicing good medicine, but also to the public. Presently we and the medical profession have too long taken the position that we're going to deal with the problem through our medical staffs or hospitals, and often times the medical staff in their efforts to deal with the problem run afoul with the governing board of the hospital which may not agree with the medical staff's disciplinary wishes. Even if you remove the staff privileges of a physician, that does not preclude him from his office practice. So the public still in unaware of the problem and still has to deal with the practitioner of the healing arts blind, so to speak.

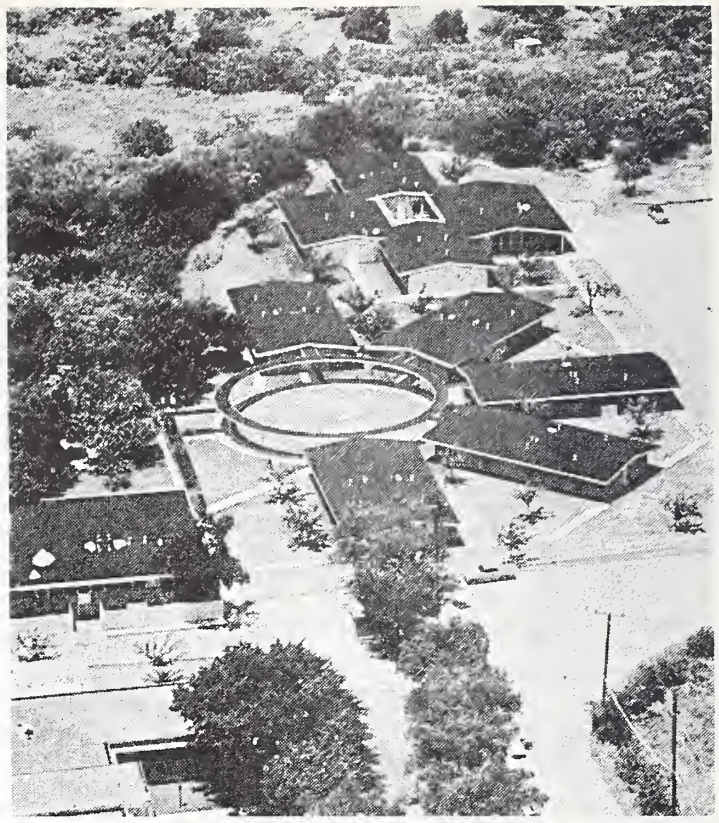
JOURNAL: Section 2 deals with the Statute of Limitations and attempts to shorten the time between the dates of an alleged event and the filing of a malpractice lawsuit. Would you please explain the provisions of this section and the effect you hope it will have on the malpractice situation.

SHORT: The section dealing with the Statute of Limitations is designed to again clarify the present Statute of Limitations. It will also have perhaps a more significant effect of bringing about a real change in what the insurance company actuaries are doing so far as their determination of the price of the insurance package. Presently, under the laws of this state, the Statute of Limitations for any personal injury or accident which includes professional negligence is two years. But the courts have interpreted that to mean two years from the date of the event or two years from the date that the person who is injured knew or should have known of the negligent act or omission on the part of the physician. When the insurance companies arrive at a premium, they are applying national statistics rather than Oklahoma statistics, and they are justifying this on the basis of saying that their experience has shown that on an eight-year average they can pretty well show that 99% of the claims will have surfaced. What we're trying to do by this statute is to require that all cases be filed within three years, and we have found by experience that at least 97% of these cases are filed within two years or within one year of the event. By this statute we are requiring that a patient-plaintiff file his lawsuit against an allegedly negligent physician within one year of learning of the event or in all cases within three years of the event. Thus, regardless of the time element involved so far as the

(Continued on Page 57)

George F. Short, LLB, is a graduate of the University of Oklahoma School of Law, and senior partner in the firm of Pierce, Couch, Hendrickson and Short. This firm handles the defense of professional liability lawsuits in southwestern Oklahoma. Short is listed among the top two per cent of all Oklahoma trial lawyers and has tried over 100 major cases in state and federal district courts.





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(Continued from Page 55)



"When the insurance companies arrive at a premium, they are applying national statistics rather than Oklahoma statistics . . ."

patient-plaintiff's knowledge, he would be cut off within three years of the event. This would have the effect of reducing this eight-year statistical average that is applied to Oklahoma physicians and reduce it to three years. The insurance carriers would have no basis for saying we are going to apply an eight-year national experience, because we have a three-year statute. This would force insurance carriers into basing their experience on Oklahoma doctors rather than on their national experience. It would also encourage insurance carriers to write their insurance in Oklahoma and would help the physicians in terms of the price.

JOURNAL: So actually this section hopefully will give the insurance companies better actuarial data and prevent them from applying national statistics to Oklahoma doctors.

SHORT: That's correct. Presently, insurance companies have collected all the premiums they're going to get for 1975. They have paid out basically what they think is a substantial amount of money for the year 1975. But they will tell you that they didn't get enough, whether they made a profit or not in 1975. And if you really pin them down, they will say, "Well, it will be 1983 before we can tell you whether we made a profit in the year 1975 or not." We want to make it easier for them, for the insurance companies to insure us; we want to make it easier for them to price the package; and we want to make it easier for them to determine their liability.

JOURNAL: Section 3 is designed I believe to give the defense attorneys in liability cases greater access to information which specifically relates to the case. Could you explain?

SHORT: Yes, this has to do with what we have called, at least, the Waiver of Privilege Bill. Now, Oklahoma's privilege statute is somewhat archaic in that it comes under the section in the statute dealing with witnesses, and it makes a physician incompetent as a witness dealing with communications given him by his patients. It was passed in 1910 along with the same sort of privileges pertaining to attorneys, priests, ministers, and other persons who are in a confidential relationship with members of the public; its purpose is to try to protect a patient and to make him feel free in terms of furnishing confidential information to his physician. Our courts have interpreted it, but the interpretation has been extended too far. What has happened is that with the advent of various types of insurance, hospitalization, disability payments, social security, etc., all of this is protected information. It allows a plaintiff who has a personal injury suit to even shop around. He can go to physician after physician after physician, until he finds one whose testimony he likes. He may testify in his own deposition, for instance, that he's been to 16 doctors and give their names, but the defendant who has that information can't go to those doctors and ask what information they have pertaining to this patient because it is protected. In other words, a plaintiff may hide the truth. We are applying this problem strictly to professional liability or medical malpractice. We are confronted presently with a case in which a surgeon is involved in surgery; there is in the room the assistant surgeon, anesthesiologist, the scrub technician, the circulating nurse, and an additional nurse. During the course of the surgery a complication occurs; the surgeon requests assistance of a specialist if there is one in the hospital. A specialist in a related field of surgery comes in to assist him in terms of the complications which have arisen, and the surgery is completed. Utlimately, a lawsuit results. Now the patient-plaintiff and his at-

torney take the position the doctor and his lawyers, and namely us, are because of this statute precluded from even interviewing the assistant surgeon, the anesthesiologist, any of the nurses, or the person that our doctor called in as a consultant to assist with the complications. They say that we are all of a sudden by reason of this statutory privilege precluded from talking with any of these other people, which to me, is ridiculous. In twenty to thirty states, I've lost count now, this statute has been passed because of criticism even in the courts in those states.In effect the statute provides that whenever a person elects to file a lawsuit, he then by that act voluntarily waives any privilege which he may have by law. In terms of justice it permits the defendant to learn and present the truth. Secondly, it has the effect of protecting the doctors. They're anxious to see that justice is done, and physicians are anxious to reveal in the interest of justice information within their possession. Physicians resent being shut up, so to speak, or having their mouths closed by the law and being forced to hide the truth when it works an injustice, for fear that by revealing the fact they would subject themselves to either (a) unethical conduct, or (b) a suit in liability. So this section really helps the physician in terms of his own ability to aid justice without liability, and secondly, to get the truth before the courts.

JOURNAL: The next section deals with the collateral source rule which has been somewhat controversial in many states. What is the advantage of this section and what effect would it have on malpractice cases?

SHORT: Section 4 deals with what is called by lawyers the collateral source rule. In effect, Section 4 of the act repeals the interpretation placed upon this problem in our court. For many years, the courts at the common law level, trial court level, and appellate level, for that matter, have taken the position that in any case where an injured plaintiff has had the foresight to insure himself with hospitalization or disability income benefits, we should not be penalized for this. So if such a person is injured through the negligence of another and sues him, he may have all of his medical expense and most if not all of his lost income paid or reimbursed from a collateral source and yet in

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"He (the patient) can go to physician after physician after physician until he finds one whose testimony he likes."

the lawsuit against the person who injured him, this fact doesn't come out. The defendant is not able to show in front of a jury that all the plaintiff's lost income has been paid or that all the medical expense has been paid. It often occurs in front of a jury that there's a guy with $10,000 in medical expenses, and $10,000 in lost wages, so here's a guy who has lost $20,000 because of this alleged injury. So the jury starts out with a feeling of sympathy. As a matter of fact, if the jury returns a verdict in his favor for these damages, he does not have to pay it back so he gets a double recovery. In other words, he gets the benefit of the collateral source payments. The jury gives the money to him again in a judgment against the third party, and he gets to collect it again in insurance, so he gets a double recovery. The rationale of the court was that the negligent defendant ought not to have the benefit of the patient-plaintiff's foresight — an expenditure of his own earnings in terms of premiums and so forth. Because of this collateral source rule, damage suit lawyers use this in evaluating their cases in terms of special damages. They'll say, "Well, my case is worth three times the damages (or five times the damages), and so if my special damages amount to $5,000, then I want $25,000 in settlement." What they do, then, is they attempt to blow up their special damages. A patient who is the least bit willing to commit fraud will go out and stay off work and draw his benefits, or he'll go to doctor after doctor after doctor seeking treatment for the sole purpose of establishing that he had a tremendous medical expense. All the time some collateral source insurance company is paying that bill, and as long as he knows it's not coming out of his own assets he'll keep inflating the damages. Many states provide for an offset. In other words, in any action for medical malpractice all these damages will be subtracted from each other automatically. We haven't gone that far; we've simply asked that this evidence be admissible in front of a jury and again, we're taking the approach that the jury is entitled to know the truth. All we have done by this section is ask that the information be brought to the jury's attention, for what it's worth. If the plaintiff's lawyer wants to show how much they paid in terms of premium payments and so forth, okay. We just think the jury ought to have the information and not be left in the dark. All Section 4 of the bill does is allow by statute the jury to have that information.

JOURNAL: The doctrine of res ipsa loquitur, dealt with in Section 5, is probably one of the most confusing factors which affect mal-



"Physicians resent being shut up, so to speak, or having their mouths closed by the law and being forced to hide the truth . . ."

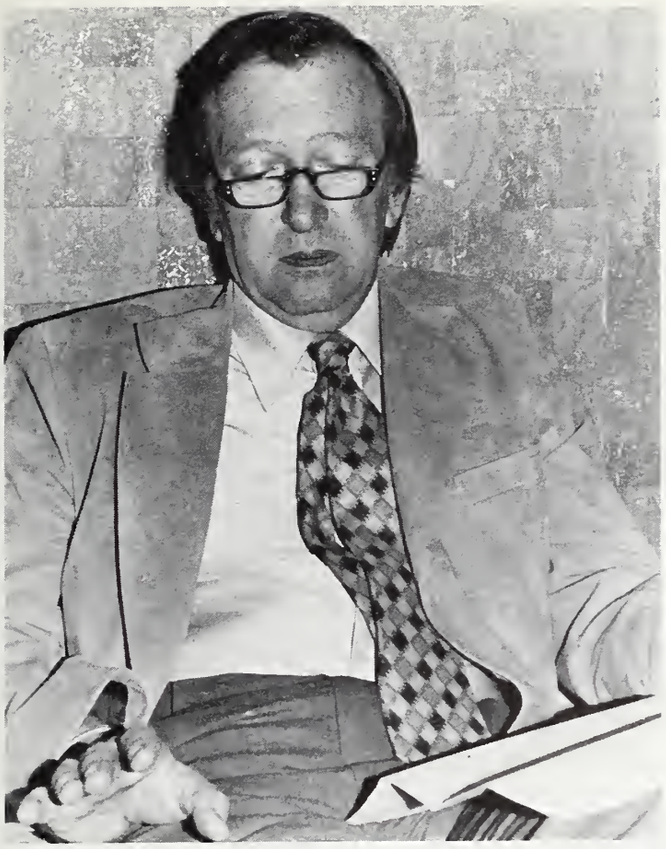
practice suits. Would you please explain the doctrine, how it is applied and any changes this section would bring about.

SHORT: Section 5 of the bill deals with the doctrine of res ipsa loquitur, which literally means, "The thing speaks for itself." This is a doctrine of law that has been in existence since the early 1800's, and originated in England. Now the doctrine is in itself somewhat of an enigma to general common law principles. By that I mean that normally the plaintiff, the person who brings the lawsuit, bears the burden of proof. It's up to him to prove that the defendant whom he sues was guilty of negligence. It's up to him to prove that the defendant not only was guilty of negligence, but negligence that directly caused his injury. Then, it's up to him to prove his damage. Now this doctrine simply shifts that burden of proof. Instead of placing it on the plaintiff it says by reason of the peculiar circumstances we are going to allow the plaintiff to go forward with his case, and the burden is going to shift to the defendant. Once the plaintiff establishes these foundation facts and brings his case within the realm of the doctrine, then, we are going to shift the burden of proof to the defendant. The only basis being that the instrumentality was within the defendant's control. Therefore, the defendant was in a better position to explain it.



". . . we're taking the approach that the jury is entitled to know the truth."

There are several examples of this. One of the best is the foreign body in the pop bottle case. There's been a myriad of these in this country against soft drink companies; these are the ones that are so well known. Anybody can readily see that you should not have a dead mouse in a pop bottle which you buy from a vendor or machine. The bottle is sealed and when you open the bottle yourself, and then you find a dead mouse in that bottle, you can say that this ordinarily shouldn't have happened absent negligence. You can also say that since it was a sealed container the instrument was solely within the control of the defendant. The information pertaining to how the bottle came to be bottled, the precautions that were taken, all this information is peculiarly within the knowledge of the defendant. That's a typical case in which res ipsa loquitur is applied. Within the last twenty years, this doctrine has been applied to the professional services type of lawsuit, medical malpractice as well as others. While we don't always have a res (we don't always have an instrumentality), we do have a situation. For instance, the instrumentality may be the patient plaintiff's body. It may be that if a patient was under anesthesia, the Court will take the position that we had the body, we being the physicians of the hospital, which was solely in our control. By use of the term instrumentality this may be a rather broad nomenclature. This has been more and more liberally construed by the Courts for lack of guidance. So we are constantly being confronted with the situation that any time an accident occurs when a patient is under anesthesia, the trial judge is willing to apply the doctrine. And we say, "Wait a minute, Judge, this shouldn't be the case. It is not a matter of common knowledge that a cardiac arrest does not occur during surgery absent negligence." As a matter of fact, all the evidence from physicians and from the medical community, will lead to the contrary; that this is a thing that does happen without negligence. What we are saying by Section 5 is that these foundation facts do apply to the doctrine of res ipsa loquitur and the medical malpractice case must be established by expert testimony. We are requiring the plaintiff to establish the facts and then produce a medical expert or a scientific expert to say, "Under these circumstances it is my considered opinion, ladies and gentlemen of the jury, that this would not occur absent negligence on the part of the defendant." And



"I think that we have a very fine bill, and I think that the bill in its present form should have an excellent chance of passing."

that's all we're asking. What we're really doing is trying to codify the common law and avoid the abortive application of it by some of our less knowledgeable trial courts.

JOURNAL: Mr. Short, as an attorney who is quite familiar with the Legislature, what is your opinion of the OSMA bill and what are its chances? Can it get through the Legislature without being diluted by amendments?

SHORT: I think that we have a very fine bill, and I think that the bill in its present form should have an excellent chance of passing. We believe that the bill should not be amended. So much time and so much effort and so much consideration have gone into the preparation of the bill in its present form that we have considered every aspect of the matter as far as we are aware. We're not talking about hours, days, or weeks; we're talking about months of preparation for this bill. We don't want amendments. Any amendment to this bill could cause severe detriment to its passage. We think that in its present form that it's hard to really justify opposition to it so that we think the bill in its present form has an excellent chance of passing.

JOURNAL: Does the fact that the OSMA has had so much input into this one particular bill preclude us or physicians across the state from supporting other "friendly" bills?

SHORT: No, we welcome our friends. We have this feeling, though, about bills, such as those which limit physicians' liability — we feel like the physicians in Oklahoma are practicing excellent medicine. We're willing to stand on our record of doing so, and we don't think that the bill limiting liability is appropriate. While there are legal opinions, particularly in Indiana, which have been put forth upholding the constitutionality of such bills, the Idaho Supreme Court recently held unconstitutional a bill limiting liability to $150,000 in medical malpractice cases. As I say, it was held unconstitutional just within the last month. We feel that this is a radical change in the system which we're not prepared for. We don't feel it is necessary at this point in time. There are other bills in the Legislature that again, we're not in opposition to, and certainly wouldn't want to say to our friends that we oppose your bill. For instance, bills that require some form of arbitration. We are concerned about these bills because it has been our experience that the very term arbitration means compromise. Compromise means payment, so that most people who would bring their cases to arbitration would receive payment of some sort. We feel that this would be



"It has been our experience that when you try to pay everybody something and nobody very much, that in effect you get nibbled to death by the ducks."

very detrimental to the maintenance of a favorable insurance market. It has been our experience that when you try to pay everybody something and nobody very much, that in effect you get nibbled to death by the ducks. It has been our experience that arbitration really doesn't work, and if it is to be a solution to the problem, we feel the wisest course for the people of Oklahoma at this point in time would be to sit back and see what happens in other states that have passed that legislation. If the results are favorable, then we might want to consider it.

JOURNAL: Is there anything that the physicians of this state can do to help get this bill passed?

SHORT: I think it's imperative that the physicians in this state get behind this bill and not adopt any sort of attitude of optimism. I think it's imperative that each physician study the bill, study its ramifications, and then urge his local senator and member of the House to get behind the bill and support its passage. I think that if the doctors of this state fail to do so, we may not get the bill. □

EDITOR'S NOTE: The OSMA endorsed professional liability bill has now been introduced before the Oklahoma Legislature. OSMA officials urge physicians throughout the state to take an interest in this bill and to work for its passage. For further information about the bill and its journey through the Legislature, see future issues of THE JOURNAL, OSMA MALPRACTICE UPDATE, and OSMA NEWS.

Changes in Medical Education Documented by AMA

A "quiet revolution" has taken place in American medical education, according to Max H. Parrott, MD, President of the American Medical Association.

Commenting on the publication of the 75th annual special "education number" of the *Journal of the American Medical Association* (JAMA), Parrott said: "The quiet revolution that has occurred in our medical educational system, to meet the changing demands of American society, has come about with very little fanfare and none of the attendant disruptions which would be part of any governmental programs designed to bring about these changes. Because the changes were voluntary and evolutionary there is every reason to believe that they will continue and that they will have a lasting impact on our medical delivery system."

Some of the trends and shifts detailed in the special issue of JAMA, dated December 29th, include:

*AMA goal of more first-line physicians attained early — 58% of all new MD's now are entering primary care residencies.

*Record number of first-year medical students — there has been a 69 per cent increase in the past ten years.

*Number of medical schools has increased by 27.

*Record enrollment of women — up 360 per cent in four years.

New Emphasis on Primary Care. It is generally accepted that if there is a physician shortage in the US, it is a matter of maldistribution by specialty. This concentration on narrow specialties drew away from the number of primary care physicians. It has also been shown that physicians trained in family practice have a greater tendency to settle in rual areas. Thus the specialty imbalance also helped exaggerate the shortage of physicians in rural areas.

The former emphasis on the specialties which was removed from primary care has now been reversed. The JAMA survey reveals that more newly-graduated physicians are entering the primary care specialties — Family Practice, General Practice, Pediatrics, Obstetrics, and Gynecology and Internal Medicine — than ever before, confirming a trend which had been identified several years earlier.

In 1973 the American Medical Association stated as "desirable" that an ideal goal would be 50 per cent of all new MD's entering primary care residency programs. That goal has been reached and surpassed.

By 1974, 58 per cent of all newly graduated medical students were entering primary care residencies.

Further evidence of this interest in primary care shows that of the 114 medical schools in the country, 96 now report a teaching program in family medicine. Two years ago only 49 schools had such programs.

Increase in Medical Students. Each year the number of first-year medical students gets larger.

In the 1974-1975 class there was an increase of 3,188 entering American medical

students over the preceding year. The total number of first-year students in 1975-1976 is 14,963. Yet with this continuing expansion, quality of instruction has remained high. For example, the student-faculty ratio continues at only 1.5 students for every instructor.

The attainment of this low ratio is the result of a phenomenon unique to the medical profession. One of every three physicians in the United States is a teacher, with the majority of these doctors teaching either part-time or voluntarily donating time to a medical school. A total of 110,740 doctors teach in American medical schools, 64,933 of whom donate their services.

The demand for admittance to medical school continues to intensify. Over the past ten years the number of applicants has risen by 122 per cent. In those same ten years the number of accepted first-year students has increased by 69 per cent.

The pre-med academic records of entering students continued to improve. In the 1974-1975 class, 39.3 per cent of entering first-year students had an academic average in the "A" range, 50.8 per cent in the "B" range and 3.0 per cent in the "C" range.

Increase in Medical Schools. During the past ten years 27 new medical schools have been started. In addition 11 more schools are in the planning stage.

But this drive to start new schools is being slowed as traditional sources of financing show signs of remaining static.

A new medical school can cost as much as $100 million, especially if there is not an existing hospital to be used for clinical teaching. But one traditional source of support, the federal government, has leveled-off, increasing by only one per cent between fiscal 1973 and 1974. Thus other sources of financial support must bear the load, including increased tuition and state government appropriations.

Still another source of additional revenue is the professional fees charged by full-time faculty members for consultations and patient care. As a percentage of the total financial support these professional fees grew from seven per cent to eight per cent in fiscal 1974.

Enrollment of Minorities and Women. Minorities continued to increase their representation in the entering class of 1974-1975.

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(Early figures for the 1975-1976 class indicate, however, that this upward trend for the blacks has been reversed. For the first time in several years fewer black students entered medical school than the year before, from 1,473 down to 1,391 students.)

Four principal minority groups were surveyed, Afro-American, Mexican American, American Indian, and mainland Puerto Rican. Each in the period surveyed has increased slightly its proportion of the new first-year student enrollment. In the 1974-1975 class, 6.5 per cent were Afro-Americans 1.4 per cent Mexican American, 0.5 per cent were American Indian and 0.4 per cent were Puerto Rican (mainland). The total enrollment of these minorities represented 8.8 per cent of the total student enrollment, up from 8.0 per cent of the previous year.

In the 1974-1975 class, women students registered a 360 per cent increase over their enrollment four years previously, making up 18.1 per cent of the total first-year enrollment. Of the 1975 graduates, 13.4 per cent were women.

Of the 8,700 women applicants, 3,260 were enrolled in the 1974-1975 class, representing 37.5 per cent successful applicants. This compares favorably with the 33.5 per cent successful male percentage.

Virtually the same percentage of women (96.8%) complete medical school as men (97.6%). A remarkably small number of students leave medical school for academic reasons, 0.45 per cent. That reflects the effectiveness of the admissions process and the dedication of the students themselves. □

Diabetes Education Clinic Opens

A new diabetes education clinic was recently dedicated at St. Anthony Hospital in Oklahoma City. The clinic's primary purpose is to educate diabetic patients and through education to make their lives easier.

The unit is sponsored by the American Diabetes Association, Western Oklahoma Chapter, Inc., headquartered in Oklahoma City. The program of classes on diabetes education began in late October with 15 diabetics, each accompanied by a family member. Ten health-care professionals are teaching the courses.

Diabetes' complications "can be delayed and prevented to some degree," says C. Alton Brown, MD, internal medicine specialist and director of St. Anthony's Hospital's new diabetes project.

"The goal of this program is to teach diabetics and their families how to control diabetes. This should eliminate, prevent or delay diabetic complications," Doctor Brown stresses.

"Also, the project strives to teach allied health personnel — dieticians, nurses, pharmacy students, medical students and other physicians — more about diabetes so in turn they can instruct the diabetic patient." An estimated 12,000 diabetics live in the greater Oklahoma City area.

Among the subjects to be covered in lectures are definitions of diabetes and changing concepts of the disease, urine testing, food for the diabetic, meal planning, insulin and oral agents, insulin administration, a diet-exchange system, treatment of insulin reactions, community programs, acute complications, exercise and its relationship to diabetes, and long term problems and complications.

Participants join the program on an outpatient referral basis from their private physicians. After the week-long course is completed, each referring physician receives a summary of his patient's prescribed diet, recommended insulin or oral drug dosage, laboratory results, progress at the center, recommendations for follow-up, and classes attended. Six Oklahoma City physicians, in addition to Doctor Brown, have volunteered to oversee the program on a rotating basis.

Doctor Brown says admission to the program is not restricted to specific age groups.

"Diabetes affects persons at all ages although it is not as common in children as adults. The incidence of diabetes is greater in adult women and with increased parity, the chance of having diabetes is increased."

The program at St. Anthony is patterned after one established a few years ago at the St. Louis Medical Center in Minneapolis, Minnesota. Doctor Brown says the director of that program, Donnell Etzwiler, MD, encouraged Oklahoma City physicians to establish a similar program here.

The story of diabetes is a giant jigsaw puzzle, Doctor Brown says, and only part of the picture has been fitted together. Research is underway to provide more answers, but in the meantime, he said, education is the most effective weapon in the battle. □

OSMA Approves Utilization Review Project

A statewide Demonstration Project on Utilization Review has been approved by Oklahoma's four largest health care professional organizations. The action was taken in late December during a joint meeting of the governing bodies of the Oklahoma State Medical Association, Oklahoma Osteopathic Association, Oklahoma Hospital Association, and the Oklahoma Foundation for Peer Review.

The Utilization Review Demonstration Project, to be funded by HEW, grew out of an attempt by the OSMA to help Oklahoma's small hospitals meet the Utilization Review requirements under the Medicare and Medicaid laws. Originally the plan was an attempt to help the hospitals comply with the regulations as written. It has now become an alternative plan that promises to be easier to implement, less cumbersome, and more economical than the Utilization Review regulations as published.

While the Utilization Review regulations currently in force call for case by case concurrent review of all Medicare and Medicaid admissions, the Oklahoma Plan is built around a "focused review" approach using retrospective audit to accomplish the same end result. The primary advantage of retrospective audit is that it can be handled through a computer screening mechanism, as opposed to a manual case by case screening necessary for concurrent review.

The Demonstration Project is based on the concept that most Oklahoma hospitals are already performing at an acceptable level and that additional review requirements, especially case by case concurrent review, will not improve the performance. Case by case review would simply be a vexation to the hospital lay and professional staffs and an added expense that would cost more than it would ever save.

The Demonstration Project is termed a "Cost Effectiveness Program," a title which is felt to be a more honest reflection of the true intentions of the original Utilization Review regulations. Its purpose is to demonstrate at an objective and reliable retrospective audit system for hospital utilization review can be designed to identify problem institutions. Once identified the plan will provide peer group supervision to assist the institution in correcting the identified deficiencies.

Although exact details of the program are still in the planning stage, the actual working concept is quite simple: A computer screening system will be developed to evaluate every hospital in the state on a statistical basis and then compare like hospitals. The screening mechanism will consist of a series of minimum standards to be established by the medical profession. If a hospital meets the established standards of the computer screening, its internal Utilization Review will consist primarily at meeting only the reporting requirements of the program and will have a minimum of physician-involvement. However, for the hospital falling outside the minimum standards, the utilization review requirements will be much more stringent and will require a great deal of physician time. The hospital thus identified will find itself doing basically the utilization review procedures outlined in the current Medicare-Medicaid regulations.

The hospital that meets the standards will be selectively rewarded by waiving or relaxing various review requirements. As an example, if a hospital meets the standards, it can automatically establish the assigned length of stay for every admission at the 75th percentile level. For the hospital that fails the standards, it will have to use the 50th percentile level for assigned length of stay. For hospitals that consistently meet the standards, the length of stay assignment might be moved to the 90th percentile level.

While the plan will contain an outline of a utilization review procedure to be used in a hospital, it does not call for a hospital to restructure a system already in place and functioning. In such an instance, the Oklahoma UR Plan will be more of a "reporting" mechanism. However, if a hospital does not have a functioning UR Committee, it can use the procedures outlined in the Oklahoma Plan.

A comparison of the Oklahoma Plan to the current Utilization Review regulations indicates that most hospitals will find themselves doing considerably less than the current requirements. Even a hospital that fails to meet the standards will be doing no more than current requirements.

In late September of last year a trial run was held evaluating all Oklahoma hospitals using a screening technique perfected by Mr. Don Penn, Vice-President for Governmental Programs (Medicare) for Oklahoma Blue Cross. Fewer than 30 hospitals failed to meet the

standards that were arbitrarily set for that one meeting. This trial run would indicate that most hospitals will not be required to do the more complicated review under the Demonstration Project.

Final planning for the Demonstration Project is currently underway. It is anticipated that the project cannot become operational until mid-April at the earliest. In the meantime, Oklahoma hospitals are gleaning one advantage: While the Demonstration Project is in planning, the Utilization Review regulations are waived. HEW assumes that the hospitals are attempting to comply with the requirements and so they are not strictly enforced. While other hospitals throughout the United States are struggling with the Utilization Review regulations as published, Oklahoma hospitals have a breather.

Projected cost of the one-year Demonstration Project is $193,000. It will require a staff of four fulltime people with professional physician-help. The project will be carried out under a contract between HEW and the Oklahoma Department of Institutions, Social and Rehabilitative Services. DISRS will then enter into a sub-contract with the Oklahoma Foundation for Peer Review to actually conduct the work.

An outside expert in writing such programs, Doctor Mel Rudov, PhD, has been employed by the foundation to work with the staffs of the OSMA and the OFPR to fill in exact details of the plan. Doctor Rudov, a psychologist, is an independent consultant with HEW and to some of the nation's largest companies. Now known as the "Oklahoma Plan," the Utilization Review Demonstration Project started out originally as an attempt on the part of Oklahoma's physicians to assist small rural hospitals to meet the requirements of federal UR regulations. In January, 1974, the then Secretary of HEW, Caspar Weinberger, published new regulations tightening up the Utilization Review requirements for hospitals wishing to participate in Medicare and Medicaid. They immediately met with strong opposition from the medical community. Serious objections were raised to many portions of the regulations. The main philosophical objection was that the regulations seemed to contradict the PSRO law by requiring hospitals to im-

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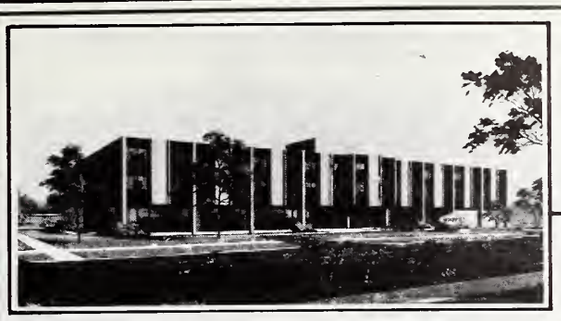
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mediately install a PSRO-like Utilization Review mechanism without the benefits of the PSRO computer technology.

The storm of objections seemed to cause the secretary to drop the proposed regulations, but on November 29th, 1974, the regulations were republished in the Federal Register in what is known as "final form." This meant they were no longer subject to review or debate, they were to be enforced as published.

The regulations required hospitals to have operational Utilization Review Committees, to set standards and criteria for all Medicare and Medicaid admissions, to review all such admissions, to establish lengths of stay for admitting diagnoses, and to conduct continuing medical education studies.

Realizing that most hospitals in Oklahoma did not have the facilities to create their own criteria and standards, the OSMA established a special Task Force on Utilization Review consisting of representatives from the Medical Association, Osteopathic Association, Hospital Association, Medicare Part A Carrier, Medicare Part B Carrier, Medicaid Carrier, Nursing Home Association, and the Hospital Licensing Section of the Oklahoma State Health Department. The Task Force was chaired by Ed Kelsay, currently Executive Director of the Oklahoma Foundation but at that time Associate Executive Director of the OSMA.

The Task Force quickly put together a one-day seminar, with appropriate educational material, to assist hospital administrators, review coordinators, and professional staffs, in carrying out the Utilization Review requirements.

The Oklahoma Foundation for Peer Review, through its Guidelines Committee, developed and published a handbook of admission criteria and length of stay guidelines for Oklahoma. The "Guidelines for Hospital Care" manual was sent to every hospital in the state and contained criteria for 106 admitting diagnoses. It was estimated that the 106 diagnoses accounted for 70 to 80 percent of all hospital admissions.

At the same time the Oklahoma Hospital Association, working with representatives from Oklahoma Blue Cross, developed a Review Coordinator's program to be used in conjunction with the Guidelines Manual. The two publications gave the hospital everything it would need to comply with the criteria and reporting portions of the Utilization Review regulations.

During January and February of 1975 a series of regional meetings was held to acquaint all Oklahoma hospitals with the material de-

veloped and published. By the end of the series of meetings, it was obvious to Oklahoma health care personnel that the new regulations were not workable in all hospitals.

Nearly 50 hospitals were identified as being unable to comply with the regulations because of personnel limitations. They simply did not have a large enough professional staff eligible to do Utilization Review.

Realizing that something had to be done to help the small hospitals, the staff of the OSMA, under the direction of its Executive Director, Don Blair, began to formulate an alternative plan to the Utilization Review regulations. The plan was built around six regional review teams that would assist the small hospitals by serving as their Utilization Review Committee.

This situation surrounding the Utilization Review regulations in early 1975 was beginning to get more and more confused. The regulations were under attack in the Federal Court by the AMA, under political attack from almost every state through their Congressmen, and subject to conflicting interpretations by various legal departments inside the HEW.

It quickly became obvious that the Oklahoma approach offered the basis for an alternative to the UR regulations that would be far more acceptable to the medical profession and much easier to implement by the hospitals.

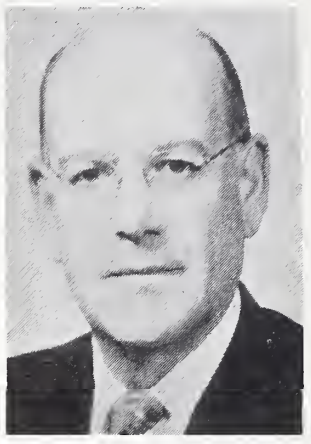
The regional review team approach combined with retrospective audit was met with enthusiasm when it was taken to Washington for presentation to HEW. The idea was ultimately approved by the Secretary and Oklahoma was encouraged to seek a special grant to conduct a Demonstration Project to show that the plan would work.

It is felt that the Oklahoma approach can actually alter the current thinking toward PSRO. The Oklahoma Foundation for Peer Review intends to use the plan as a test vehicle for innovative approaches to PSRO planning. It is possible that the plan could alter national policy by causing amendments to be made in the PSRO law and its regulations.

The plan has already received national recognition. Several other states, recognizing the advantage of the approach being used, have sought permission from HEW to implement such a plan. In each case, HEW has refused by indicating it is relying on Oklahoma to prove or disprove the concept. □

Second Annual William K. Ishmael Lecture Slated

Joseph Lee Hollander, MD, Professor of Medicine at the University of Pennsylvania School of Medicine will be the Visiting Professor of the Department of Medicine at the University of Oklahoma Health Sciences Center during March 3rd, 4th, 5th, 1976. Doctor Hollander will be making ward rounds, with emphasis on clinical aspects, differential diagnosis, and management of various rheumatic disorders. On Wednesday, March 3rd at 12:15, he will be the principal participant of the Medical Grand Rounds. On Wednesday evening the Oklahoma Rheumatism Society will hold a social hour and dinner, followed by a scientific meeting with participation by Doctor Hollander.



On Thursday, March 4th, Doctor Hollander will deliver the "Second Annual William K. Ishmael Lectureship in Rheumatology" on the Immunopathogenesis of Rheumatoid Arthritis. On Friday, March 5th, he will participate in Orthopedic Grand Rounds.



Doctor Hollander is one of the best known rheumatologists in America, and is internationally known for his teaching and research in rheumatology. He has been the Editor-in-Chief of *"Arthritis and Allied Conditions"* since 1948, and is the author of over 120 scientific papers on arthritis and related disorders. He was formerly on the Editorial Board of the *Annals of Internal Medicine, Arthritis and Rheumatism, Archives of Inter-American Rheumatology,* and *The Journal of the American Medical Association.* He received the Distinguished Service Award from the Arthritis Foundation in 1958, 1962, 1965 and 1970. He has been President of the American Rheumatism Association, and is a member of many medical societies in the United States and honorary member of several foreign societies in internal medicine and rheuma-

tology. Doctor Hollander has been a Diplomat of the American Board of Internal Medicine since 1944, and a Master of the American College of Physicians since 1972.

The primary purpose of Doctor Hollander's visit to Oklahoma City is to give the Second Annual W. K. Ishmael Lecture in Rheumatology. The establishment of this program in rheumatology honors Doctor Ishmael, who is a Clinical Professor of Medicine at the University of Oklahoma Health Sciences Center, for his many years of dedicated service. This materialized the efforts of Doctor Lyman C. Veazey in helping to establish continuing medical knowledge in arthritis for the practitioner in Oklahoma, and it is made possible through an anonymous bequest. □

Atlanta Graduate Medical Assembly To Convene

The Medical Association of Atlanta will sponsor its 33rd Annual Graduate Medical Assembly, March 14th-17th, 1976, at the OMNI International Hotel in Atlanta.

Sessions on March 15th and 16th will be devoted to perinatology. Guest speakers for these meetings will be: Frank H. Boehm, MD, Director of Obstetrics and Gynecology, Vanderbilt University Hospital, Nashville; L. Joseph Butterfield, MD, Chairman, Department of Perinatology, University of Colorado Medical Center, Denver; Douglas W. Cudmore, MD, Assistant Professor, Department of Obstetrics and Gynecology, Dalhousie University, Halifax, Nova Scotia; Stanley N. Graven, MD, Professor, Department of Pediatrics, University of Wisconsin, Madison; Edward H. Hon, MD, Chief, Perinatal Research, Los Angeles County-University of Southern California Medical Center, Los Angeles; and H. Belton P. Meyer, MD, Adjunct Assistant Professor, Department of Pediatrics, University of Arizona College of Medicine, Phoenix.

Registration fee for out-of-state physicians is $100.00 and $50.00 for members of sponsoring societies, the Greater Atlanta Pediatric Society, the Atlanta Obstetrical and Gynecological Society and the Georgia Academy of Family Physicians.

Additional information may be obtained from Wynnell S. Hopkins, Executive Secretary of the Atlanta Graduate Medical Assembly, 875 W. Peachtree Street, N.E., Atlanta, Georgia 30309. □

AMA Will Fight Federal Trade Commission Complaint

The American Medical Association has vowed to fight a recent Federal Trade Commission complaint that ethical constraints against physician advertising constitutes a restraint of trade. The FTC ruling was made public December 22nd, 1975, through the media.

According to the complaint, the three respondents (the AMA, the Connecticut State Medical Society, and the New Haven County Medical Association) have agreed to prevent or hinder competition between medical doctors by enforcing ethical regulations against advertising. The FTC further complained that by enforcing these regulations, the AMA has interfered with physician fees, prevented competition between doctors, and deprived consumers of the information they need to select physicians.

Both the AMA and the OSMA were hampered in responding to the complaint since the press was aware of the complaint long before any medical society. However, in a joint statement by Raymond T. Holden, MD, AMA chairman, and Max H. Parrott, MD, AMA president, AMA officials pointed out that the Code of Ethics was more than 100 years old and "devised and operated as a standard of conduct in the best interests of the patient." The statement further pointed out that most professionals considered advertising to be the antithesis of professionalism.

The two doctors said there was enough hucksterism in this country without hucksterizing medicine, and they vowed to fight the complaint.

OSMA President Arnold G. Nelson, MD, took a similar stance in opposing the FTC complaint. Because of the seriousness of the matter, Dr. Nelson's complete statement is shown here.

"The Oklahoma State Medical Association thinks it is ironic that the Federal Trade Commission, on the eve of the Bicentennial year, would want to force the medical profession to step back 100 years into an era of hucksterism in medicine. One hundred years ago unqualified practitioners preyed on the public through false advertising, and to once again encourage this would be an unfortunate step backward into the past. The OSMA considers the FTC's complaint against the AMA's ethical constraints against advertising by

physicians to be totally unfounded and without just cause.

"When the once widespread diploma mills were put out of operation and medical hucksterism was largely stopped, the American Medical Association was responsible. Quality medical schools were established and the professional status of medicine was greatly enhanced through the efforts of ethical medical doctors — not the federal government.

"The OSMA agrees with the AMA's statement that, 'Advertising by a professional is the very antithesis of professionalism.' Health care is not a common good or commodity, and it should not be merchandised as such. Advertising by health practitioners would bring out the worst elements of a variety of practitioners who are licensed by the various states, but who cannot compete successfully on the merits of their professional skills.

"While the hundreds of medical services and surgical procedures do not readily lend themselves to advertising and common price comparisons, competition in medicine does in fact exist. Referrals for specialized services are made by primary care practitioners to ethical and highly qualified physicians and surgeons who have earned the respect of their peers. Thus, cost and quality controls are maintained by the peer group itself, a group of professionals best qualified to make such judgments.

"While physicians should not engage in merchandising their talents and fees, health insurance companies are engaged daily in an effort to encourage the public to buy adequate protection against the costs of illness. Even here, we sometimes see inferior policies being sold through misleading advertising. As a rule of thumb, the OSMA suggests that adequate coverage for a single individual should cost no less than $20-$25 a month, and about $50 to $70 a month for a family. The OSMA does not believe this part of a family's budget is unreasonable, since it is less than the typical person or family spends on an automobile and on other consumer items which are less valuable than good health.

"The OSMA believes very strongly that it should remain unethical for physicians and other respected professionals to advertise their services and fees; nothing good would come from this and much would be lost. Truth in advertising is a worthy goal which, unfortunately, has not been universally achieved. In Oklahoma, a state law considers advertising by bona fide health professionals as being 'unprofessional.' We would hope that the Federal Trade Commission would not attempt to override the sovereignty of state government in this instance." □

DEATHS

C. L. TEFERTILLER, MD
1916-1975

C. L. Tefertiller, MD, Altus surgeon for 27 years, died December 16th, 1975. Doctor Tefertiller, 59, was born in Arnett, Oklahoma, and received his medical degree from the University of Oklahoma College of Medicine in 1942. Following a few months of practice in Ada, Oklahoma, he established his practice in Altus. Doctor Tefertiller had served as a Trustee to the Oklahoma State Medical Association for many years.

RICHARD F. SHRINER, MD
1921-1975

Richard F. Shriner, MD, former Hobart, physician, died in Oklahoma City on December 4th, 1975. Doctor Shriner, born in Cordell, Oklahoma, was awarded his medical degree from the University of Oklahoma College of Medicine in 1944. His residency was in orthopedics.

H. C. MORRISON, MD
1896-1975

H. C. Morrison, MD, a retired Oklahoma City physician, died December 15th, 1975. Born October 4th, 1896, Doctor Morrison received his medical degree from the University of Tennessee College of Medicine in 1924. He practiced in California, Tennessee and Maud, Oklahoma before establishing the Morrison Clinic in Oklahoma City in 1936. Doctor Morrison became a Life

Member of the Oklahoma State Medical Association in 1971 and was a member of the Sigma Chi.

DAVID J. UNDERWOOD, MD
1898-1975

A Tulsa pediatrician since 1929, David J. Underwood, MD, died December 8th, 1975. Born in McLeansboro, Illinois, Doctor Underwood was graduated from the Northwestern University Medical School in 1925 and practiced in Chicago before moving to Tulsa. An Army veteran of World War I, Doctor Underwood was a Life Member of the Oklahoma State Medical Association.

A. M. BREWER, MD
1901-1975

A long-time Oklahoma City physician and former Oklahoma City Councilman, A. M. Brewer, MD, 74, died December 8th, 1975. A native of Berlin, Oklahoma, Doctor Brewer was graduated from the University of Oklahoma College of Medicine in 1927. He practiced in Oklahoma City for over 47 years before his retirement. Doctor Brewer was a Fellow of the International College of Surgeons and the American College of Surgeons, and was affiliated with the American Society of Abdominal Surgeons.

PHIL J. DEVANNEY, MD
1906-1976

Phil J. Devanney, MD, 69, former Sayre, Oklahoma, physician, died at his home in Bella Vista, Arkansas, January 24th, 1976. A native of Denison, Texas, Doctor Devanney was graduated from the University of Oklahoma College of Medicine in 1931 and had practiced in Sayre for 41 years before moving to Arkansas. He had served as President of the Beckham County Medical Society. In 1973, the OSMA presented Doctor Devanney with a Life Membership for his years of devoted service.

G. A. KILPATRICK, MD
1887-1975

Former Henryetta, Oklahoma, physician, G. A. Kilpatrick, MD, died in Coral Gables, Florida, November 22nd, 1975. Doctor Kilpatrick, 89, was born in Missouri and received his medical degree from Tulane University School of Medicine in 1914. For over a half-century of practice and dedicated service to humanity, Doctor Kilpatrick had been honored by the OSMA with the presentations of a Life Membership and membership in the Fifty Year Club.

GILBERT E. HASLAM, MD
1900-1975

Gilbert E. Haslam, MD, Anadarko, eye, ear, nose and throat specialist, died in Tulsa on November 7th, 1975. Doctor Haslam was the father of Gilbert E. Haslam, Jr., MD, Tulsa pediatrician. Born in Piedmont, Alabama, he was a 1924 graduate of Emory University School of Medicine. He established his practice in Anadarko in 1935.

DAVID V. HUDSON, MD
1896-1976

Retired Tulsa physician, David V. Hudson, MD, 79, died January 20th, 1976 in Tulsa. He was the husband of the late Doctor Margaret G. Hudson.

Born in Sinchang, China, Doctor Hudson was graduated from the John Hopkins University School of Medicine in 1923. He established his practice in Tulsa in 1930. He was the former, longtime director of the Tulsa City-County Health Department in charge of the communicable disease program and established the initial venereal disease control program in Tulsa.

Both he and Mrs. Hudson were honored in 1964 when they were named "Doctors of the Year" by the Auxiliary to the Tulsa County Medical Society. In 1966, Doctor Hudson was presented an Honorary Life Membership in the OSMA. □

WELL-TRAINED physician in Family Medicine or General Practice needed immediately for medium-sized Oklahoma city with outstanding hospital facilities and full range of specialty care. Existing practice nets $60,000 a year. Contact Key W, *The Journal,* Oklahoma State Medical Association, 601 NW Expressway, Oklahoma City, Oklahoma 73118.

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May
6th, 7th, 8th, 9th, 1976

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Oklahoma City, Oklahoma

Doctors' Wives Day at the Legislature
March 16th, 1976
State Capitol Building 8:30 a.m.

Landmark malpractice legislation with the endorsement of Governor Boren, OSMA, and many prominent law makers will have been introduced by the time you read this article.

It is as important to us as physicians' wives to support this freedom for medical practice as it was for the patriots to fight for what they believed two hundred years ago. Medical practice has in fact been stifled and many unwarranted examinations are ordered on the basis of our present tort system. We must do everything in our power as individuals to obtain passage of this law which contains some new concepts in jurisprudence and therefore will be opposed by many legislators.

The secret is individual and personal contacts with legislators and many letters. The ladies who attended this same conference two years ago will recall Senator Boren stating that six letters was considered heavy mail.

This law which is to be introduced is very similar to the very recently adopted *"model"* Michigan statute.

It is imperative that we take an active role in obtaining passage this year and for these reasons it is a *must* for every physician's wife in Oklahoma who can, to attend this special day at the Legislature. Malpractice will be discussed from the legal point of view, insurance stand, medical point of view and legislative review.

Luncheon will be served at the OU Medical Faculty House.

For more information contact Shirley Forsythe, (Mrs. John T.), Tulsa, or the OSMA.

Make plans now
to attend
March 16th, 1976, 8:30 a.m.
State Capitol Building.

OSMA JOURNAL / *the last word*

A grass-roots campaign to promote physician interest in medical malpractice legislation was kicked-off recently by a new OSMA publication—OSMA MALPRACTICE UPDATE. The new publication will give periodic reviews of the malpractice situation and it will trace OSMA endorsed legislation through the Legislature. S.B. 622, largely researched and written by OSMA officials and members of the Legislative Committee, was released from bill drafting shortly before press-time and by now should have been introduced at the Legislature. OSMA officials expect to meet with some strong opposition and urge every doctor in the state to lend support to S.B. 622. No standard publication schedule has been chosen for MALPRACTICE UPDATE; events at the Legislature will determine when and how frequently it goes to press. Each physician in the state is urged to read this new publication and to file it for future reference.

The Annual Meeting of the OSMA House of Delegates will be held April 9th-11th, 1976, at the Skirvin Hotel in Oklahoma City. This year's meeting will be held approximately one month before Oklahoma Medical Summit '76 to allow the 160 delegates to participate fully in the various sessions of Summit. The meeting will officially begin in the afternoon of April 9th with a meeting of the OSMA Board of Trustees. The opening session of the OSMA House of Delegates will be held Saturday morning, April 10th, and the closing session will be held during the morning of Sunday, April 11th.

The nation's struggling economy apparently will weigh heavily in any final decision concerning national health insurance. President Ford has already said he does not feel the American people can afford to pay for a plan as costly as NHI. Apparently his thinking has filtered down to some other people closely associated with investigating the proposal. At a recent AMA National Leadership Conference, three persons well-versed on the issue and familiar with Capitol Hill procedures were asked how long it would be before a NHI bill was introduced before Congress—the average estimate was 33 months. Other federal failures and the exorbitant costs that would be associated with NHI seem to have had a pronounced effect on people's thinking. Evidently, a lot of people are beginning to wonder how the federal government plans to administer a nationwide health insurance plan after Medicaid and Medicare have proven so costly.

"The most divisive war in our history still divides Americans. A United States Army force has been defeated by ill-equipped guerrillas. The American elective process has been contravened. The most deadly sort of racism is rampant and the law is oppressive. A Presidential administration has been exposed as corrupt. The economy is in a shambles. Crime is rising. Our citizens live in fearfully overcrowded cities and many of their children are denied a basic education. Is this a time to have a national birthday party?

All of these points were raised when the United States was celebrating its Centennial in 1876. The memory of the Civil War was still vivid, and even as Philadelphia began its Centennial observance, word came that General Custer's command had been slaughtered at the Little Big Horn. Samuel B. Tilden had outpolled Rutherford B. Hayes but Congress handed the Presidency to Hayes. The Ku Klux Klan was riding high and Texas was living under the Lynch Law. The Grant Administration had been virtually dismantled by scandal. The country was still reeling from the 1873 panic and workers found their incomes slashed by as much as 50 per cent. In Philadelphia the murder rate jumped 75 per cent during the Centennial year. In New York more than 250,000 people were found living in a single square mile area. Of 600 school-age children living in the Five Point Section of New York, only nine were attending school.

"Why celebrate then? Why celebrate now?" *New York Times,* May 18th, 1975

One hundred years ago the country had serious problems and many citizens wondered how long it could last. Today we still have problems, but the country is still here. In 2076, the conversation will likely be the same, the problems will be different, and the United States will still be here. □

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Our Greatest Resource— Why Isn't It Supported?

"While children and youth represent more than 35% of the total population of the United States, they are the recipients of only 15% of the total amount of $80 billion expenditures for health care."[1]

The crux of this editorial is contained in the above statement. If children and youth are our greatest resource, as I believe them to be, rather than the "forgotten American,"[2] the major disparity in support of their welfare as compared to that provided for older age groups should be corrected.

In addition to the discrepancies in outlay of funds in favor of the older age groups, there are other important considerations which must be included. Assignment of priority status or importance to specific diseases simply on the basis of the relative number of deaths each causes fails to take into account other important public health dimensions. For example, in any recent year heart diseases, cancer and stroke account for about 66% of all deaths in the United States. Yet these conditions are predominantly causes of death among older people. However, the death of an infant or a fetus produces an average loss to society of more than 70 years of life, including more than 50 years of productivity and a 100% loss of reproductivity. The death of only 18 children at age seven years results in the loss of as many future years of life as the death of 100 persons at age 70. If the loss of life before birth to only one cause — congenital malformations — as added to those due to this cause occurring postnatally, the total of 560,000 is second only to heart disease as a cause of death in the United States each year and is 15% greater than those due to cancer and stroke together.[3]

Recent reports have shown that not only are there differences in medical care-spending based on age, but both the size and type of expenditures for medical care are directly associated with age. Cooper and Piro,[1] in their analysis of national medical care statistics for FY 1973, report that an estimated $80 billion was spent in that period for personal health care. Of this amount, only 14.5% was spent for children and youth under 19 years of age, although they represented 34.7% of the population; 56.7% went for persons aged 19-64 (55.3% of the population), and 28.0% for those 65 and over (10.0% of the population). On a per-capita basis, the $1,052 yearly medical-expenditure for aged persons was almost triple that for the intermediate age group ($384) and over six times the per capita amount for a young person ($167). The discrepancy in expenditure would be even greater if the traditional definition of children (less than 21 years of age) was used.

Furthermore, the rate of discrepancy between expenditures for the old and young continues to increase. In 1973, expenditures rose fastest for persons aged 65 and over — 11.6%, compared to 7.6% for those less than 19 years of age and 9.9% for those 19-64 years of age.[1]

Also varying with age was the source of financing for personal health care outlays. Although 62% of the total overall was contributed by private funds, and the rest by federal, state and local governments, the proportion financed by each source differed considerably among the three age groups. Public funds accounted for 29% of expenditures in the under-19 age group, 27% in the 19-64 age group, and a whopping 64% in the 65-and-over group. Thus government obviously has become the primary purchaser of health care for the aged, mainly due to implementation of the Medicare and Medicaid programs in the mid-1960s.

Cooper and Piro's statistics also point out some interesting differences in the composition of the medical care bill for each age group. For each of the two older groups, nearly one-half of their outlays went for hospital care (47.7% for the 19-64 age group, 48.4% for the 65-and-over group), far exceeding any other item of expenditure. In contrast, young persons spent only

30.4% of their total medical care bill for hospital services, approximately the same amount spent for physician's services (31.8%). The two older groups had spent only 22.4% and 17.7%, respectively, for physician's services. The other most obvious differences in type of spending occurred in the categories of "other professional services" (12.8% for the young, 10.5% for the intermediate group, only 3.3% for the aged) and, as would be expected, nursing-home care (0.8% for the young, 1.0% for the intermediate group, 14.1% for the aged).

Comparison of the FY 1973 statistics to those of previous years[1] revealed some interesting trends in personal health-care-spending. Between 1967 and 1973, personal health care expenditures averaged increases of 12% a year, reflecting results of both inflation and increased use of services (this seven-year period was the first seven years that Medicare and Medicaid were in operation). In FY 1973, however, the rate of increase had slowed to 10% overall, which is attributed partly to the economic stabilization program acting to depress inflation.

Identified as the most significant trend in recent years was the shift in the source of funds for medical care, with government assuming an ever-increasing share of funding. Although the most dramatic shift occurred among the elderly — public funds paid for 30% of their health bill in 1966 and 64% by 1973 — the public share for all those under 65 also grew, from 19% in 1966 to 28% in 1973.

In fact, third parties in general — government, private health insurance, philanthropy, industrial in-plant services — are financing a much greater share of the health care bill than they did a few years ago.[1] Third parties paid less than one-half of a person's average health care costs in 1966, but nearly two-thirds in 1973. For the individual, this partly offsets recent increases in average per capita amounts spent on health care: from $182 in 1966 to $375, more than double the amount, in 1973.

For children and youth, the 1973 per capita expenditure of $167.15 for health care was about 44% of the amount spent for individuals in the intermediate age group, and only about 16% of that spent for the elderly. Although admittedly care of the aged is going to be more expensive, particularly when the costs of extreme efforts to prolong life and of custodial care are included in the medical bill, it still would appear that children and youth do not receive a fair proportion of the funds expended for health care.

Wallace and Goldstein,[4] in a study of costs of child health care in the United States, not only reach that conclusion but continue to show that the extent of coverage of children and youth, even those in various high-priority groups, is limited. For example, in 1972 the 76 Children and Youth Projects served only 487,000 of the 15,400,000 high-priority children and youth. However, for those children that these comprehensive-care projects did serve, per capita costs ($128.00 for 1972-73) were comparable to and even slightly less than the national average that year for persons under 19 ($146.86 in FY 1972).[2] This comparison is significant, for its shows that comprehensive health care can be provided by an interdisciplinary team at reasonable cost. Of course the problems of financing of child health care are complex, but it is good to know that the costs of organized, community-based, comprehensive health-care programs need not exceed those of health care provided in a more traditional manner and need not incur the high cost overruns characteristic of Medicare[5] and Medicaid ($301.87 per capita for 1971.)[2]

Although we need more studies of expenditures for various types of health care programs to determine relative costs more accurately, it would appear from present data available that (1) expenditures for child health care lag far behind those for adults, and (2) any increase in expenditures for children and youth might best be directed toward the equalization of access to care. Haggerty[5] has reported estimates that some 15% to 20% of children in the United States lack access to care. Availability of financial assistance cannot entirely remedy this, as Haggerty notes, for professionals may not be available in the areas of need, transportation may be lacking, or there may be overwhelming social problems in the family. It is in grappling with these geographical and social barriers to complete health care that organized programs for children from low-income families, such as the Children and Youth Projects or Neighborhood Health Centers, may help most in expanding coverage to all children. And despite the fact that these new interdisciplinary programs include such services as outreach, public health nursing, and other services needed in "underdoctored" and socially deprived areas,

per capita costs are not necessarily higher than for medical care provided in the more traditional manner.

Careful study and evaluation of these types of data on health care expenditures and extent of coverage for children and youth should serve as a basis for future planning for the use and re-direction of public funds designated for child health care. (Wallace and Goldstein suggest, as a first step in redirecting the use of existing funds, the channeling of Medicaid funds into the development, expansion, and strengthening of present, more cost-efficient comprehensive-care programs for children and youth.) Attention to systematic future planning is particularly important in light of the increasing proportion of health care financed by public funds and the possible enactment of a national health insurance program in the near future.

It is clear that nationally more than twice as much money should be directed toward the health care of children than is currently the case. It is highly significant that in 1973 the per capita health care expenditure for the elderly ($1,052.00) is almost seven times that for children and youth ($167.15).

Furthermore, that for the young adult and middle aged group ($383.67) is more than 2¼ times that for children and youth. Thus, no matter how one looks at the situation, children and youth are not receiving their fair share of funds expended for health care.

ACKNOWLEDGEMENT

Appreciation is expressed to K. L. Woodworth for assistance in preparing this article.

REFERENCES

1. Cooper BS, Piro PA: Age differences in medical care spending, fiscal year 1973. Social Security Bulletin, May 1974, Washington D.C.: DHEW Publication No. (SSA) 74-11700.
2. Fleming, AM: Our children — without them there is no future! Clinic. Pediat. **14**:92-95, 1975.
3. Riley, HD, Jr: Human Teratology. South Med J **61**:317-320, 1968.
4. Wallace HM, Goldstein H: Child health care in the United States: expenditures and extent of coverage with selected comprehensive services. Pediatrics **55**:176-181, 1974.
5. Haggerty, RJ: Expenditures for child health care (editorial), Pediatrics **55**:160-161, 1974.

Harris D. Riley, Jr., MD

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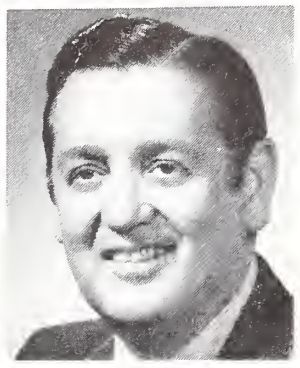
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"A Solution To The Doctor Shortage Problem of Oklahoma!!"



The greatest need in medical manpower today is more well-trained Family Physicians. The second most pressing problem in medical manpower is to place physicians in physician shortage areas. I believe that both the specialists and the generalists alike, would welcome some way to achieve this goal.

For many years, the Oklahoma Academy of Family Physicians has been encouraging medical students to enter Family Practice. The fact is well established that this is the physician most likely to enter practice in physician shortage areas, such as smaller towns and communities in Oklahoma. It now appears that they have reached their goal in students who desire to enter residency programs in Family Practice in the state of Oklahoma. Now there is a new problem, that being a shortage of residency positions in Oklahoma.

In October, 1975, Howard P. Mauldin, MD, Chairman of the Medical School — OAFP, Liaison Committee, mailed an unbiased questionnaire to 560 medical students currently enrolled at the Oklahoma University School of Medicine and he received 190 signed returns. This is a 34% overall response which is average for this type of questionnaire. Breaking the 190 returns down into year of graduation is as follows: Of 36 seniors who responded, 13 indicated Family Practice as their first choice which is 36%. If this percentage carries throughout the Senior class, we would need approximately 50 places for first-year Family Practice residencies. The residency program has been expanded and in 1976 can accommodate 24 first-year Family Practice residents, which is less than 50% of what is needed. In the Junior Class, there were 42 responses and 23 (or 54%) indicated Family Practice as their first choice. In the Sophomore Class, there were 58 responses and 28 (or 48%) indicated Family Practice as their first choice. In the Freshman Class there were 54 responses and 32 (or 59%) of those answering gave Family Practice as their first choice.

I would point out that 350 of 560 (or 62%) students at the Oklahoma University College of Medicine are Student Affiliate Members of the Oklahoma Academy of Family Physicians. This represents the highest percentage of membership in the nation. Dean Tom Lynn estimates that this poll is correct, and estimates that 35% of the graduating class at this time plans to enter Family Practice residency programs which, in fact, means that these students will be leaving the state of Oklahoma to obtain their residency training and statistics indicate that most students tend to locate for practice near the site of their training.

Fellow physicians, it is too expensive for our state to train Doctors, and then lose them to some other state after graduation.

I believe the physicians, across this great state, will be encouraged by the high percentage of the medical students who desire to enter the practice of Family Medicine. It is up to all the physicians of Oklahoma, the Legislature, the hospitals, the medical planners, and all other citizens of Oklahoma to join together and take the necessary action to keep these doctors in Oklahoma.

Arnold G. Nelson, M.D.

OSMA JOURNAL / scientific

Echocardiography Today:

A valuable aid for the diagnosis of cardiac disease

W. H. OEHLERT, MD
CHARLES BETHEA, MD
LOTFY BASTA, MD

Echocardiography has become a valuable tool in the noninvasive diagnosis and assessment of heart disease.

The value of echocardiography as an extremely useful tool in the diagnosis and evaluation of heart disease has been firmly established. The echocardiogram is obtained by directing pulsed ultrasound waves through the heart. Reflected echos are produced whenever the sound beam meets an interface of tissue of different density within the chest. The recording of these waves constitutes the echocardiogram. The test is non-invasive, harmless, inexpensive, and can be repeated as deemed necessary. Its ability to identify cardiac chamber dimensions and valve motion places the value of echocardiography with that of routine chest films and electrocardiograms in the diagnosis and assessment of heart disease. In addition, information obtained through echocardiography not infrequently obviates the need for cardiac catheterization. However, the technique has certain requirements and limitations; The basic requirements for producing accurate information from the echocardiogram are:

1. A suitable ultrasonic system designed for generating and recording cardiac echos.
2. A properly trained technician to perform the study.
3. A qualified physician who has the expertise necessary to supervise the technician, perform the procedure when complex information is required, interpret the results and apply the obtained information to the clinical situation.

The test is limited in that the coronary vessels cannot be visualized and that technically adequate echocardiograms are difficult to obtain in the very obese or those with advanced emphysema.

Echocardiography provides positive anatomic diagnosis in patients with mitral or tricuspid stenosis, mitral valve prolapse, asymmetric septal hypertrophy with or without outflow tract obstruction, intracardiac masses, or pericardial effusion. A presumptive diagnosis can be made in aortic stenosis (valvular or subvalvular), bicuspid aortic valve, right ventricular volume overload, cardiomyopathy, prosthetic valve dysfunction, ruptured chordae tendineae, aortic lesions and most of the congenital heart diseases. Recently, echocardiography is being utilized increasingly in the assessment of left ventricular performance and myocardial contractility.

An adequate echocardiographic study includes an evaluation of the cardiac valves (mitral, aortic and often tricuspid and pulmonary), septal and ventricular wall thickness and motion as well as dimensions of the aorta, left atrium, left ventricle and right ventricle, and definition of the pericardium. Figure 1 shows the most commonly used

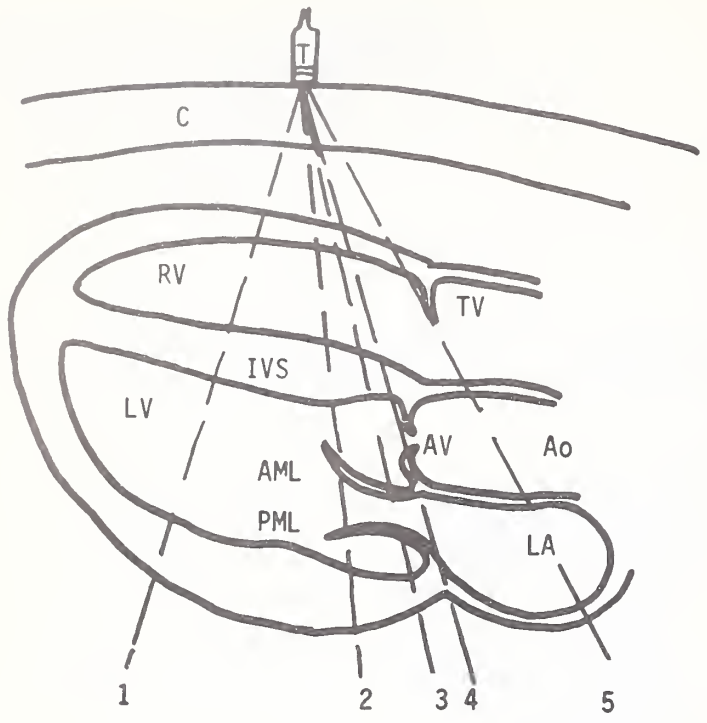


FIGURE 1

Diagrammatic representation of the direction of ultra-sound beam through different planes of the heart with transducer angulation. T: Echocardiogram transducer, C: Chest wall, RV: Right Ventricular chamber, TV: Tricuspid valve, IVS: Interventricular septum, LV: Left ventricular chamber, AML: Anterior mitral valve leaflet, PML: Posterior mitral leaflet, AV: Aortic valve, Ao: Aorta, and LA: Left atrium.

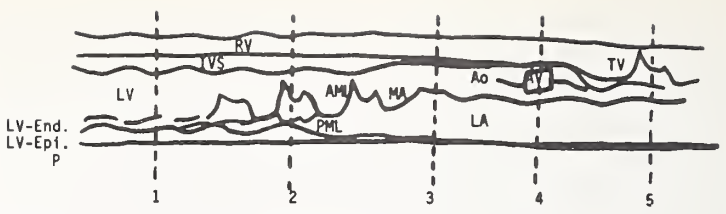


FIGURE 2

Normal M Mode echocardiogram scan of the heart. RV: Right ventricular chamber, IVS: Interventricular septum, TV: Tricuspid valve, LV: Left ventricular chamber, LV-End: Left ventricular endocardium. LV-Epi.: Left ventricular epicardium, P: Pericardium, AML: Anterior mitral valve leaflet, PML: Posterior mitral leaflet, MA: Mitral annulus, Ao: Aorta, AV: Aortic valve, and LA: Left atrium. Numbers 1 through 5 correspond to the echocardiographic beam directions illustrated in Figure 1.

transducer positions and Figure 2 is a diagrammatic representation of the normal M Mode echocardiogram scan of the heart directing the ultrasound beam initially towards the cardiac apex and moving its direction gently (by angling of the transducer) in a plane from the apex towards the base of the heart.

The mitral valve echocardiogram is often used as the focal point for obtaining the total echocardiogram. It has a characteristic pattern of motion that allows for easy recognition. Figure 3 illustrates the normal mitral valve echographic pattern and its labeling. Mitral stenosis causes a decrease in the float close motion of the anterior leaflet (reduced "E-F" slope), parallel motion of the posterior with the anterior leaflet in diastole, and heavier leaflet echos (Figure 4). Tricuspid stenosis shows a similar leaflet motion anterior to the interventricular septum. Mitral valve prolapse exhibits a late systolic or holosystolic posterior motion of mitral valve echos particularly those from the posterior mitral valve leaflet. Late mitral valve prolapse is illustrated in Figure 5. Aortic insufficiency can be suspected from high frequency fluttering of the anterior mitral valve leaflet and of the interventricular septum associated with an increase in left ventricular chamber diastolic dimension, (Figure 6).

A 1967 graduate of Washington University School of Medicine. William H. Oehlert, MD, is certified by the American Board of Cardiovascular Disease and serves as Assistant Clinical Professor of Medicine at the University of Oklahoma Health Sciences Center. He is a Fellow of the Council on Clinical Cardiology and the American College of Cardiology; a member of the American Heart Association, the American College of Physicians and the American Society of Internal Medicine.

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Lotfy Basta, MD, graduated from Cairo University, Egypt, in 1955. He is certified by the American Board of Internal Medicine and Cardiology and is presently Professor of Medicine and Head of the Cardiovascular Section at the University of Oklahoma Health Sciences Center. Doctor Basta is a Fellow of the American College of Physicians and the American College of Cardiology. He is a member of the American Heart Association and a Fellow of the Council on Clinical Cardiology.

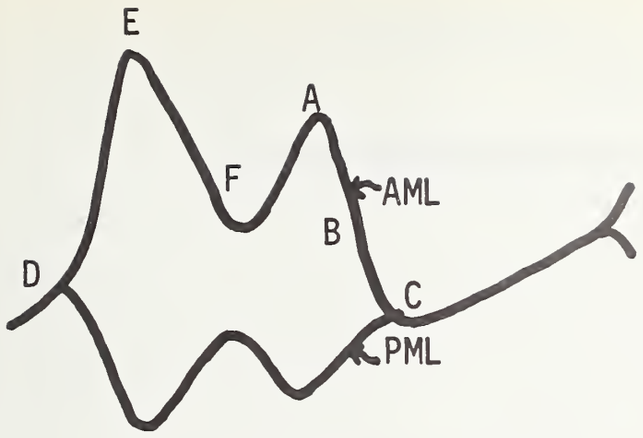


FIGURE 3

Normal Mitral Valve. AML: Anterior mitral leaflet, PML: Posterior mitral leaflet, A: "a" wave due to atrial contraction, B: Closing slope of the AML at the end of ventricular diastole, C: Closing point of the mitral valve where the AML and PML meet, D: Separation point of the AML and PML at the beginning of ventricular diastole, E: The most anterior point of the AML during early ventricular diastole, and EF slope: The float close motion of the AML during the early phase of ventricular filling.

Asymmetric septal hypertrophy may be seen without left ventricular outflow obstruction (ASH), or with obstruction (idiopathic hypertrophic subaortic stenosis-IHSS). The disease is diagnosed when the ratio of the interventricular septal thickness to left ventricular posterior wall thickness exceeds 1.3 (normally it is 1:1.2). In addition to increased interventricular septum thickness, IHSS manifests systolic anterior motion of the mitral valve (Figure 7) that encroaches upon the left ventricular outflow tract.

Prolapsing atrial myxoma produces a group of echos seen posterior to the anterior mitral leaflet during diastole and in the left atrial cavity during systole.

Pericardial effusion causes a separation of the pericardium from the ventricular epicardium. The demonstration of pericardial effusion requires technical expertise in the control of sensitivity settings of the machine and direction of the ultrasound team. In Figure 8, the pericardial effusion is referred to as "PE."

Echocardiography, in expert hands, is particularly sensitive in detecting pericardial effusions as small as 20 milliliters. By comparison, fluoroscopy and cardiac scanning techniques generally fail to demonstrate effusions of less than 300-400 ml.

Echocardiography is extremely valuable in the assessment of common cardiology problems:

1. Large heart by X-ray: Echocardiograms can distinguish congestive cardiomyopathy from pericardial effusion and other less common causes of cardiomegaly such as Ebstein's malformation of the tricuspid valve.

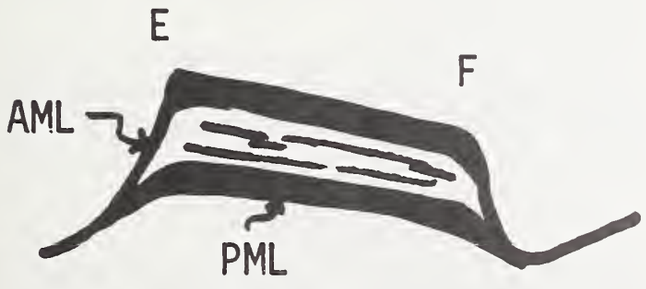


FIGURE 4

Mitral stenosis. The mitral valve echocardiogram is characterized by a decreased EF slope, anterior motion of the PML, and thickening of the valve leaflets.

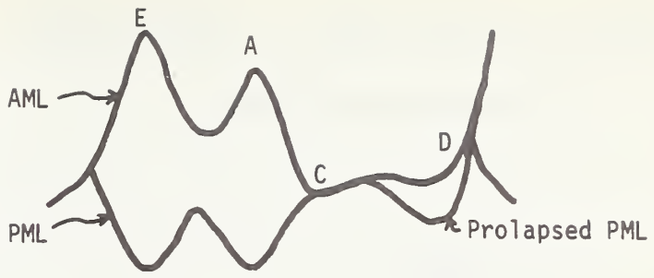


FIGURE 5

Mitral valve prolapse. The mitral valve echogram is characterized by mid to late posterior displacement of the PML during ventricular systole.

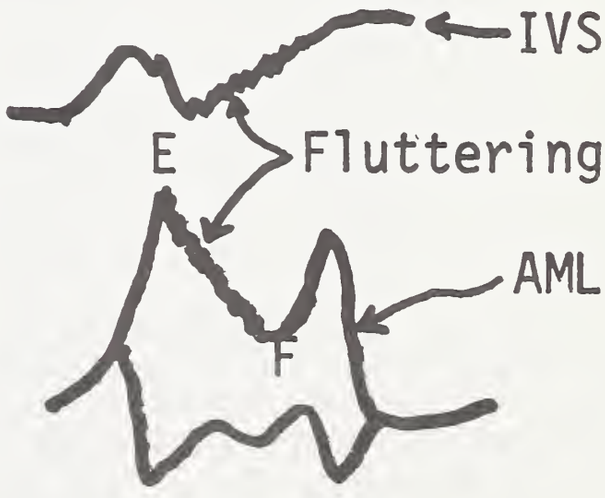


FIGURE 6

The echocardiogram in aortic insufficiency. Aortic insufficiency is characterized by high frequency fluttering of the anterior mitral valve leaflet and interventricular septum in early diastole. The left ventricle is also dilated.



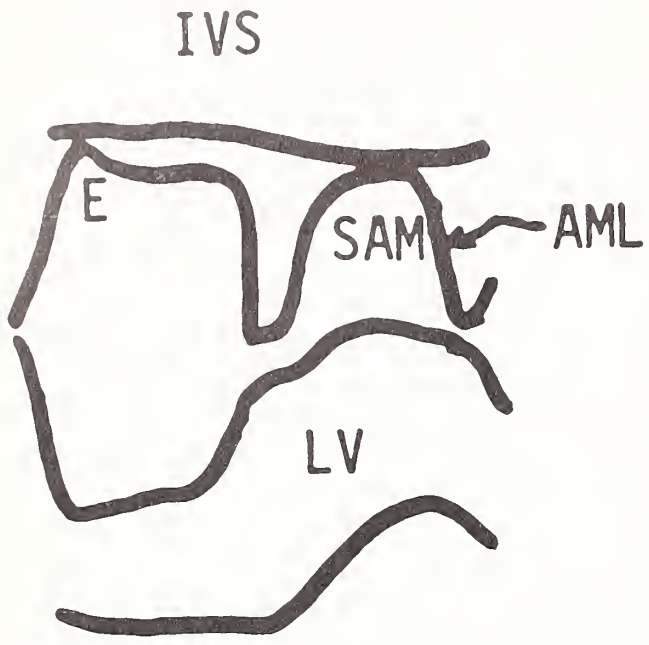


FIGURE 7

Idiopathic hypertrophic subaortic stenosis (IHSS) is characterized by a thickened IVS, anterior displacement of the mitral valve, and systolic anterior motion (SAM) of the AML obstructing the left ventricular outflow tract.



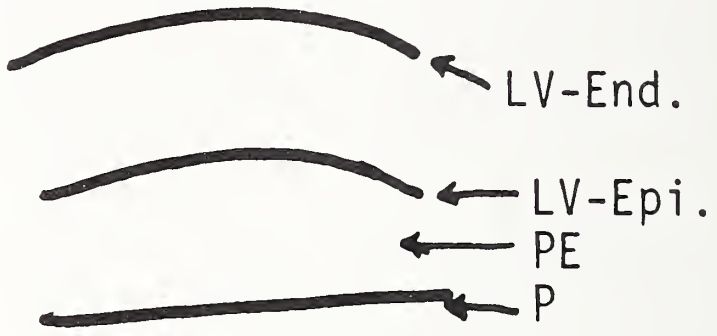


FIGURE 8

Pericardial effusion. An echocardiogram of pericardial effusion shows separation of left ventricular epicardium and the pericardium (P). Normally, LV-Epi. and P. are not separated as shown in the upper panel. In pericardial effusion, LV-Epi. and P. are separated by the Pericardial Effusion (PE) as illustrated in the lower panel.

2. Congestive heart failure symptoms with a small cardiac silhouette: The differential diagnosis in such cases includes silent mitral stenosis, restrictive cardiomyopathy, constrictive pericarditis, pure aortic stenosis, and atrial myxoma, all of which can be defined with echocardiography.

3. Innocent pulmonic murmur versus left-to-right shunt: a volume overloaded right ventricle is suggested from paradoxical interventricular septum motion and right ventricular chamber enlargment. These findings are not present with an innocent murmur.

4. Apical murmurs: Idiopathic hypertrophic subaortic stenosis, fixed orifice aortic stenosis, mitral valve prolapse, rheumatic mitral insufficiency and ruptured chordae tendineae may cause apical systolic murmurs. The echocardiogram has highly specific findings in IHSS, mitral valve prolapse and aortic valve stenosis. Rheumatic mitral regurgitation may be suggested from thickened mitral valves. Ruptured chordae tendineae can often be identified but require special expertise.

5. Pleuritic chest pain: Pericarditis often produces atypical chest pain and the effusion may not be sufficient to cause an increase in cardiac size on the chest X-ray film. A carefully performed echocardiogram is often diagnostic of small pericardial and/or left pleural effusion.

An exciting potential of echocardiography is in the assessment of left ventricular performance in various cardiac disorders and its modification with treatment; also, in the follow-up of patients for the earliest signs of increase in chamber size or deterioration of left ventricular function.

Echocardiography is increasing in value in the diagnosis of congenital heart disease in infants and children as well as in adults.

REFERENCES

1. Popp, R. L. and Lopes, M. G.: Echocardiography in cardiac diagnosis. Diagnostic methods in cardiography. Cardiovascular Clinics Vol. 6, No. 3: 199-218, 1975.

2. Feigenbaum, H.: Echocardiography. Lea and Febiger, Philadelphia, 1973.

3. Joyner, C. R.: Ultrasound. Year Book Medical Publishers, Inc. Chicago, 1974.

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Malignant Melanoma at St. John's Hospital, Tulsa, Oklahoma

JOHN FORREST, BA
DAMON GREGG, MD

All patients discharged from St. John's Hospital, Tulsa, Oklahoma, with a diagnoses of melanoma over a ten-year period were reviewed in regard to location, treatment and prognosis for a comparison with other areas of the nation.

INTRODUCTION

A review of the cases of malignant melanoma encountered on the surgery service at St. John's Hospital, Tulsa, Oklahoma, from 1967 to 1971.

METHODS

Forty-five cases of malignant melanoma treated surgically from 1967 to 1971 were reviewed. The tumor registry was used as the source for the historical data. Each case was evaluated on the following criteria. The age, sex and race of each patient was noted. The anatomic location of the tumor was recorded. Histologic classification was performed on each tumor according to the classification of Clark.[1] Level I referred to tumor confined above the basal lamina. Level II referred to tumor which has penetrated the basal lamina and extended into the papillary layer of the dermis. Level III referred to tumor which has filled the papillary layer of the dermis and accumulated at the junction of the papillary and reticular dermis. With level IV invasion, the tumor has distinctly invaded the bundles of collagen of the reticular dermis. Level V referred to tumor which has penetrated the subcutaneous fat.

Each tumor was also classified into three histopathologic categories. According to Clark,[1] these are: (1) Lentigo Maligna Melanoma, (2) Superficial Spreading Melanoma and, (3) Nodular Melanoma.

Lymphocytic response was estimated by the lymphocyte population at the tumor margin. This was rated on a one- to four-plus scale.

The history of the development of the lesion was also recorded. This included recording whether or not a nevus preceded the development of the malignancy.

The method of surgical treatment was recorded. This included wide excision with a primary closure, wide excision with a split thickness skin graft, excision with an *en bloc* regional lymph node dissection, and wide excision followed by a regional lymph node dissection.

Recurrences along with patient status at two year post-surgery and five year post-surgery (where applicable) were also recorded. Those patients lost to follow up were excluded from the series.

RESULTS

The average age of occurrence was 48.8 years of age. The range was 14 years of age to 75 years of age. The sex ratio was 2:1, female to male.

All but one of the patients in this series were Caucasian. The single Negro patient was also the youngest patient in this series.

The anatomical site of occurrence appears below in Table I. This was also analyzed in respect to sex.

TABLE I

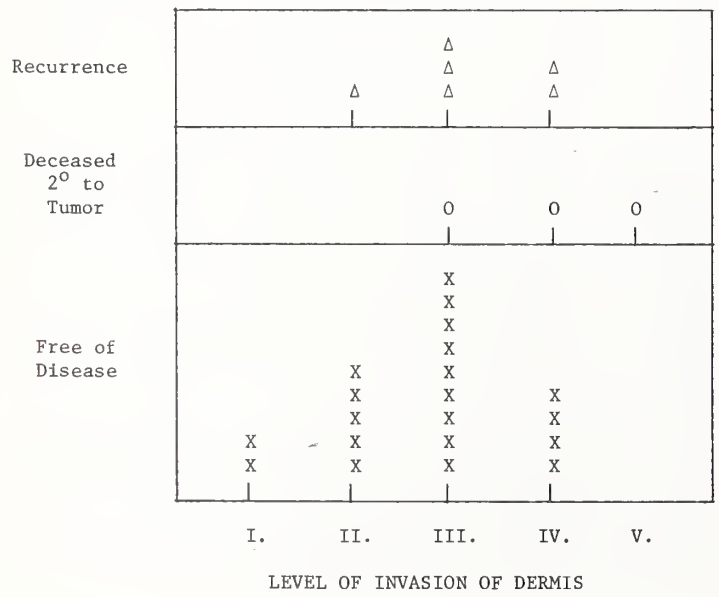
Site of Occurrence	Males	Females
Head and Neck	37.5%	16.6%
Upper Extremity	12.5%	29.1%
Trunk	37.5%	20.8%
Lower Extremity	12.5%	33.3%

Melanomas occurring in males were found most often in the head and neck region and the trunk. Sixty-two percent of the melanomas occurring in females were found either on the upper or lower extremity.

The nodular form of malignant melanoma occurred most often. It was found in all locations. The superficial spreading form of malignant melanoma occurred much less commonly. It was also found in all locations. The lentigo maligna melanoma occurred once in this series. It occurred on the temple.

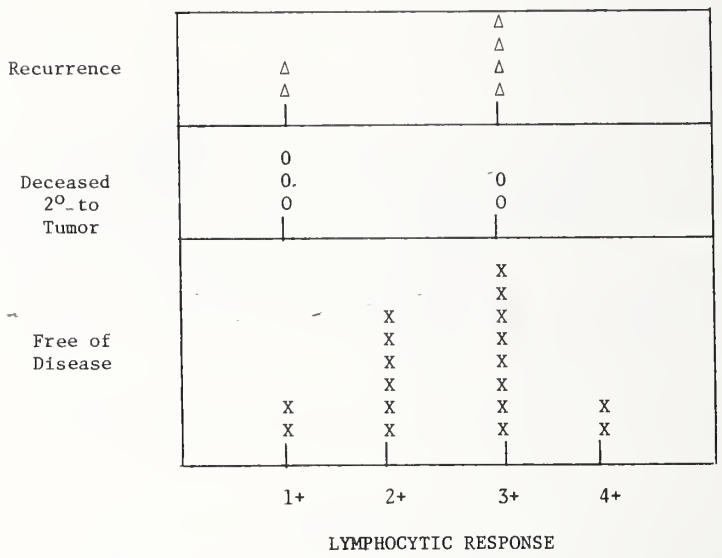
The depth of invasion of the dermis was plotted against survival and recurrence in Table II. The tumor-related deaths occurred only with level III or deeper. This was also true of the tumor related recurrence. One recurrence occurred with a level II primary tumor.

TABLE II.



The degree of lymphocytic response was plotted against survival and recurrence. The results are seen above in Table III.

TABLE III.



The role of regional lymph node involvement

TABLE IV.

	Two Year Survival
Positive Node Involvement	55%
Negative Node Involvement	90%

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Damon Gregg, MD, graduated from the University of Oklahoma College of Medicine in 1959. Doctor Gregg interned at St. John's Hospital, Tulsa, Oklahoma, and was in private practice from 1960 to 1971. He is a Diplomate of the American Board of Family Practice and is currently in private practice in Midwest City.

in this series is shown in Table IV. Positive node involvement only occurred with level III or deeper invasion.

A nevus preceded the development of the melanoma in 45% of the cases studied. In 34% of the cases, the patient denied the existence of a nevus preceding the development of the melanoma. The remaining 21% of the patients were not certain as to whether a nevus was present before the melanoma developed.

The various therapy modalities were correlated with five year survival. Wide excision with a primary closure showed a 100% five-year-survival for level III lesions. Wide excision with a split thickness skin graft for level III lesions showed a 66% five-year-survival. Wide excision followed with a subsequent lymph node dissection had a 60% five-year-survival. It should be noted that only three of fourteen cases of level III melanomas in this series were treated with wide excision and primary closure.

There were four cases of level IV lesions in this series. One case was treated by wide excision with a primary closure. Two cases were treated by a wide excision followed by a subsequent lymph node dissection. The remaining case was treated by wide excision with an *en bloc* lymph node dissection. Level IV lesions treated by wide excision showed a 100% five-year-survival. Wide excision with an *en bloc* lymph node dissection for level IV melanomas had a 100%mortality. Level IV lesions treated by a wide excision with a subsequent lymph node dissection had a 50% five-year-survival.

The single level V lesion in this series was treated with a wide excision with an *en bloc* lymph node dissesction. The patient was deceased at two years post-surgery.

TABLE V

Two year survival—45 cases	
two year survival free of disease:	88%
recurrence at two years:	7.1%
mortality at two years:	4.7%
three cases lost to follow-up	
Five year survival—24 cases	
five year survival free of disease:	58.3%
recurrence at five years:	16.6%
mortality at five years:	25%

Survival was computed on a two- and five-year basis. When follow up was unavailable, those cases were left out of the survival statistics.

Two-year survival statistics were also computed with respect to depth of invasion of the dermis. Patients with level I and level II tumors were all free of disease at two years. Level III tumors were associated with an 11.8% recurrence rate, a 24.2% mortality and a 64% non-recurrence rate. Level IV tumors were associated with a 28.4% recurrence rate, 14.2% mortality rate, and a 57.4% non-recurrence rate. Patients with a level V tumor were associated with a 100% recurrence rate.

DISCUSSION

The age distribution showed that malignant melanoma was uncommon but not rare under thirty years of age. The most common decades for the occurrence of malignant melanoma were those from forty to seventy years of age. Petersen *et al*[2] showed a preponderance for the sixth decade of life. The youngest case in this series was a fourteen year old black male. The histologic diagnosis for that case was malignant melanoma arising in a cellular blue nevus. The cases that occurred in patients over seventy years of age comprised all of the three different histologic diagnoses. Mihm, Clark, and From[3] described the median age of onset of the various histologic types of malignant melanoma. They were as follows: (1) lentigo maligna — 70 years of age, (2) superficial spreading — 56 years of age and, (3) nodular — 49 years of age. In this series, the average age of onset of the various histologic varieties was as follows: Lentigo maligna (one case)—70 years of age, superficial spreading — 47 years of age, and nodular — 50 years of age.

The sex distribution of the tumors was 2:1, female-to-male. The relatively small number of cases in this series may have not reflected the sex distribution of the tumor. Petersen[2] *et al* also showed a 2:1 female-to-male ratio. Hansen and McCarten[4] showed a 60%-40% female-to-male ratio. They also reported the following anatomical site and sex distribution of the tumors. The melanomas occurring on the head and neck were 32% of the total. They occurred 56% in males and 44% in females. Those melanomas of the trunk were 23% of the

total and occurred with equal frequency in males and females. Those melanomas occurring on the extremities accounted for 45% of the total. They occurred on males in 22% of the cases and on females in 78% of the cases. Lee[5] reported an increased mortality in females with melanoma of the lower extremity. He suggested that this was secondary to more direct sunlight exposure of the female lower extremity. He also reported that the melanomas of the female lower extremity tended to be of the superficial spreading variety. Those tumors were also associated with a younger age of onset.

The depth of invasion of the dermis by the tumor has been shown by Mihm, Clark, and From[3], Hansen and McCarten[4], and McGovern[6] to correlate directly with survival. The data presented in this series agreed with their observation.

Hansen and McCarten[4] suggested that lymphocytic response correlated well with prognosis. The data reported in this series are not clear with respect to prognosis and lymphocytic response. (See Table V) However, it was noted that those patients who survived showed a moderate to good lymphocytic response. Histologic grading of lymphocyte response obviously did not determine the tumorcidal potential of those lymphocytes. McGovern[6] could not draw any conclusions regarding prognosis and lymphocyte response. Huvos *et al*[10] stated in their study of melanomas of the head and neck that the extent of the lymphocytic response seemed to have no effect on prognosis.

Lymph node involvement either by physical exam or by lymph node dissection with positive histologic findings worsened the prognosis of malignant melanoma. Rippey[7] quoted data which show a 17% five-year survival with positive lymph nodes. The data reported in this series agree with that conclusion.

Robbins[8] in his pathology text expressed the opinion that the majority of malignant melanomas arise within a pre-existing nevus. The data presented in this series shows that 45% of the patients reported a nevus being present prior to the development of the tumor. However, 21% of those patients in this series could not recall whether or not a nevus preceded the development of the tumor. It therefore appeared that at least half of malignant melanomas develop within a pre-existing nevus.

The data presented in this series were inadequate to support a clear conclusion regarding the optimal surgical treatment for level III or deeper melanomas. Hansen and McCarten[4] suggest that in the management of Stage I lesions, tumor thickness is the guide for management. They suggest that for Stage I lesions 1.5 mm or greater in thickness a prophylactic regional lymph node dissection should be performed. This improved survival in their series. The role of prophylactic lymph node disssection in Stage II or deeper lesions was not clear. Gumport and Harris[9] state there was benefit to be gained from elective regional lymph node dissection performed selectively for invasive melanoma. This was supported by the finding that there was an 18% false negative clinical estimation of nodal involvement.

SUMMARY

A series of forty-five patients from St. John's Hospital with malignant melanoma was presented. Parameters of age, sex, anatomic site, histologic classification, lymphocytic response, lymph node involvement, history of a pre-existing nevus, and therapy modalities are discussed.

APPRECIATION

The authors would like to thank Doctor Bryce Bliss, Doctor Herbert J. Forrest and the Department of Pathology, St. John's Hospital, Tulsa, Oklahoma, for their assistance.

BIBLIOGRAPHY

1. Clark, W. H., Jr., From, L., Bernardino, E. A., *et al:* The histogenesis and biologic behavior of primary human malignant melanomas of the skin. **Cancer Res. 29:**705-727, 1969.

2. Petersen, N. C., Bodenhan, D. C., Lloyd, O. C.: Malignant melanomas of the skin. A study of the origin, development, etiology, spread, treatment, and prognosis. **Br. J. Plast. Surg. 15:**49-94, 1962.

3. Mihm, M. C., Clark, W. H., From, L.: The clinical diagnosis, classification and histogenic concepts of the early stages of cutaneous malignant melanoma. **N. Engl. J. Med. 284:**1078-1082, 1971.

4. Hansen, M. G., McCarten, A. B.: Tumor and lymphocytic infiltration in malignant melanoma of the head and neck. **Am. J. Surg. 128:**557-561, 1974.

5. Lee, J. A. H.: Fatal melanoma of the lower limbs and other sites: An epidemiologic study. **J. Nat'l. Cancer Institute 44:**257-261, 1970.

6. McGovern, V. J.: The classification of melanoma and its relationship with prognosis. **Pathology 2:**85-98, 1970.

7. Rippey, J. J.: A review of the classification of malignant melanoma. **S. Afr. Med. J. 47:**528-530, 1973.

8. Robbins, S. L.: **Pathologic Basis of Disease.** Philadelphia: W. B. Saunders Company, 1974.

9. Gumport, S. L., Harris, M. N.: Results of regional lymph node dissection for melanoma. **Ann. Surg. 179:**105-106, 1974.

10. Huvos, A. G., Mike, V., Donnellan, M. J., Seemayer, T., Strong, E. W.: Prognostic factors in cutaneous melanoma of the head and neck. **American Journal of Pathology 71:**33-45, 1973.

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OSMA JOURNAL / special

Famous Scientific Hoaxes

Part 2

ERNEST LACHMAN, MD

The Kammerer affair which ended in the suicide of the famous, but controversial biologist, represents one of the most sensational scientific controversies of this century.

THE KAMMERER CASE

The case involving Doctor Kammerer has been called the greatest scientific scandal of the early part of this century. It concerns the tragic story of the outstanding biologist Doctor Paul Kammerer, who on September 23, 1926, at the age of 46, was found in the hills of lower Austria shot through the head, with a suicide note identifying the dead as Doctor Paul Kammerer. Doctor Kammerer's personality was quite complex and can be better understood in the framework of his environment, the Vienna before and after World War I. Vienna at that time was a city of sophistication and decadence, of political unrest, culturally in part under the influence of its Jewish upper middle class, yet a hotbed of antisemitism and a breeding place of political intrigue and economic instability. It was the original source of the saying: "The situation is desperate, but not serious." Vienna at that time was the city of Hoffmannsthal and Schnitzler, Mahler, Werfel and Max Reinhard, to name just a few of its great writers, composers and dramatists. It was also the mecca of postgraduate medical education for the Western world, the city of Freud and many other famous physicians and scientists and the home of many illustrious singers, musicians, and actors. In spite of the political disintegration, theater, literature, and music flourished. In Kammerer's personality and life these divergent forces left their mark. He was a ladies' man involved in many often serious love affairs, with both of his marriages ending in divorce. He was a linguist and known as a fascinating lecturer. He had an almost saintly love of all living creatures, but particularly of reptiles and amphibians, which he could handle better than any other scientist. In keeping with his philosophy he refused to undertake any experiments that subjected his animals to pain. He named his daughter after his favorite species of lizards, Lacerta. Politically he championed the rights of the underprivileged and was a partisan of the Austrian socialist movement. He blamed, quite convincingly, his controversial scientific stance and his partially Jewish origin for his lack of academic advancement. Originally he wanted to become a composer and pianist and attended the Viennese Conservatory for Music as a talented pupil. Later he switched to zoology, a field in which he received his PhD degree and obtained

an academic position in the Institute for Experimental Biology, known as the Vivarium. The Vivarium was located within the confines of the large Viennese amusement park, the famous "Prater," somewhat symbolic of the intertwining of research and play.

During the scientifically productive period of his life Kammerer published numerous papers which culminated in a book entitled, *The Inheritance of Acquired Characteristics* in which he claimed to have proved by his breeding experiments on salamanders and toads that certain acquired characteristics are passed on to the next generations. This was of course contrary to Darwin's and the Neo-Darwinists' theory of evolution. They relied on incidental mutations and natural selection of those variations most suitable for survival of the organism in a given environment. Thus Kammerer set himself against Darwinism and revived the teachings of Lamarck in the early part of the 19th century, whose theories were based on the supposition that useful adaptive changes acquired during the lifetime of the organisms could be transmitted to their offspring. The acrimonious discussion that followed Kammerer's claims pervaded the volumes of the highly respected scientific British Journal, *Nature,* for almost ten years. Many eminent biologists were found on either side of the argument. The most outstanding geneticist of this period, William Bateson, challenged Kammerer and questioned the veracity of his experiments. Kammerer's goal was to produce modifications in the color, physique or mating habits of animals by breeding them in an environment completely different from their normal surroundings.

His most controversial experiment concerns the midwife toad, Alytes. Most species of toads mate in water while the male clasps the female around the waist and waits for her to spawn. In order to retain its hold on the female, the male develops during the mating season swellings on its palms and fingers with small horny spines of black color. These swellings are called nuptial pads. By contrast the midwife toad copulates on land and therefore does not have or require such pads. The female spawns jellied strings of eggs which the male fertilizes and then winds around his hindlegs, hence its name. Kammerer asserted that by inducing Alytes to copulate in water for several generations it develops the previously described pads and transmits this feature to its offspring. Kammerer bred these toads for five generations and displayed the specimens in the Vivarium in Vienna and in England, where they were seen and studied by many biologists. Scientists of the Western world divided themselves into trusting believers who called Kammerer the modern Darwin, a group exemplified by the Cambridge zoologist, E. W. MacBride. By contrast his antagonists regarded Kammerer as a charlatan, not averse to falsifying his experimental results. The outstanding representative and mouthpiece of this group was Bateson.

A stunning blow destroyed Kammerer's reputation, when Dr. G. K. Noble, curator of reptiles at the American Museum of Natural History, published a revealing article in the August 7, 1926 issue of *Nature*. In it he reported that in the early part of 1926 he had visited Kammerer's Viennese laboratory and with his permission and that of the director of the institute, he carefully examined the last alcohol-preserved specimen of Alytes, which had weathered the destruction of the Vivarium by bombing and other vicissitudes of war. He stated that he discovered the absence of nuptial pads in the specimen and also the shocking finding that the black coloration of the pad was caused by an injection of India ink. The latter fact was confirmed by the director of the institute who was a close friend of Kammerer's. The result for Kammerer was devastating. It released a chain of vituperative articles, particularly in England, and six weeks later Kammerer killed himself.

Before one tries to pass any judgment on Kammerer one has to visualize the demoralizing influence that the lost war and the political and economic breakdown of the Austrian empire had on its cultural and scientific institutions. Even wealthy academicians were com-

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pletely pauperized. Kammerer himself after 15 years of concentrated research work, which lead to numerous publications and many invitations for scientific and popular lectures all over the Western world, was financially ruined by the economic disaster. An outsider can hardly imagine the influence that the astronomic inflation exerted on the morale and life-style of the greater part of the population, particularly the middle classes. Long before the fatal denouement Kammerer had to give up his academic position in order to recoup his financial losses through popular writings and lectures in England and the United States. His precarious financial situation and his ever-recurring love affairs had brought Kammerer to a state of near mental breakdown where manic and depressive phases alternated.

Shortly before his death he received from Moscow an offer of a professorship for Hereditary Science combined with the request to found a biological department affiliated with Pavlov's Institute. In the Soviet Union Kammerer's theories were particularly welcome, since they fitted so well into the edifice of communistic thought and Karl Marx's and Engels' teaching. According to their philosophy man is a product of his environment which could easily be manipulated to produce changes in his undesirable traits, a theory that also applies to animals and plants.

Kammerer accepted the position offered to him by Moscow and a week before his suicide furnished the Russian embassy in Vienna a detailed list of equipment needed and gave instructions as to their shipment to Moscow where his work was to start on October 1. In spite of the discovery of the fraud in Kammerer's institute, the Soviet Academy of Sciences did not retract its offer. Apparently the Soviets had not lost their confidence in Kammerer's character and work. It was Kammerer who in a suicide note the day before his death declined the invitation stating that, although he had nothing to do with the forgery, he did not regard himself as a suitable candidate for the position. In Western Europe, however, popular and scientific journals and the textbook literature condemned him as a forgerer and mountebank (Beck, Cannon).

Until recently there was no biography of Kammerer in existence that impartially investigated his personality and the controversial scientific evidence as elaborated in his papers and books. In 1971 the renowned writer Arthur Koestler published a splendidly documented history of Kammerer's scientific work, that led to his downfall, and as much of his life history as is necessary for the understanding of his complex personality. Koestler sifted the scientific evidence objectively and although he started his investigation doubting Kammerer's veracity, in the end he appeared convinced that Kammerer himself did not undertake the falsification. However, Koestler feels that he cannot completely exclude the possibility of Kammerer having injected the ink himself in an act of desperation, but he deems this quite unlikely. Kammerer was such an accomplished experimenter and skillful dissector that he would not have undertaken such a clumsy forgery. We should not forget that Kammerer personally gave permission to inspect and handle the specimen. The latter had been known to scientists who examined it thoroughly in Vienna, Cambridge and London without raising any objections to the actual presence of nuptial pads and the black coloration. Photographs and sections had been made available and sent to Bateson in England. It can be assumed that the fraudulent injection into the gradually decaying specimen was done after its return from England and shortly before Noble's visit.

But who did it? As has been pointed out, it is unlikely that Kammerer himself undertook the falsification. It is however conceivable that a loyal technician, who perhaps was in love with Kammerer, committed the forgery in order to preserve the appearance of the famous specimen. The opposite is also possible and was suspected by Kammerer's chief, the famous professor Przibram, ie, that a jealous staff member tried to discredit Kammerer's reputation and scientific veracity. Przibram, while not disputing the fraud, staunchly believed in Kammerer's personal innocence and integrity and pointed that out repeatedly before and after Kammerer's death. It is interesting to note that, although Kammerer had so many opponents among the scientists in his field, nobody ever was able to repeat Kammerer's well known breeding experiments on toads and salamanders. Only few scientists seem to have tried it, but failed, while Kammerer succeeded in producing five successive generations. Nevertheless the fact cannot be excluded that Kammerer's vacillating and histrionic personality may have played tricks on him. Thus, Alma Mahler-Werfel, the femme fatale of that

period in Vienna, reports in her autobiography that Kammerer, who was deeply in love with her, appointed her — after the death of her husband, Gustav Mahler — as his laboratory assistant. In this capacity she got to know him quite well and observed him at work. She felt that meticulous and time consuming protocols of his experiments were not to his liking. He wanted positive results. But she admits that he was exceptionally gifted, honest, and not given to falsifications. She states that if any of these took place, Kammerer was not aware of them, but responded to his unconscious drive to produce innovative and startling results.

Parenthetically it must be stated that Kammerer's experiments, while revolutionary, do not necessarily prove that Lamarckian inheritance of acquired characteristics is the guiding principle of evolution. Other explanations of Kammerer's results can be found, such as the reversal to atavistic traits under the influence of the environment. With the advent of molecular biology pure Darwinism is again under scrutiny. A number of contemporary biologists are convinced that Darwin's theories of random mutation and natural selection cannot fully explain the evolutionary process. While Kammerer's conclusions can be questioned, the monumental edifice of his important experiments should be re-checked with the assistance of modern laboratory methods.

In conclusion it is noteworthy that in the Kammerer affair as well as in the Piltdown fraud the guilt of both men, who were originally branded as the sole perpetrators of these fraudulent hoaxes, has now under more sober and critical scrutiny become quite doubtful.

REFERENCES

1. Beck, W. S.: *Modern Science and the Nature of Life*, p. 220. Doubleday and Company, Inc., Anchor Book, New York, 1961.
2. Cannon, H. G.: *Lamarck and Modern Genetics*, pp. 43-47. C. C. Thomas, Springfield, 1959.
3. Kammerer, P. *The Inheritance of Acquired Characteristics*. Boni and Liveright, New York, 1924.
4. Koestler, A.: *The Case of the Midwife Toad*. It also contains a complete list of references to Kammerer's scientific publications and books. Random House, New York, 1971.
5. Koestler, A.: *Der Kroetenkuesser. Der Fall des Biologen Paul Kammerer*. Verlag: Fritz Molden, Wien, Muenchen, Zuerich, 1971.
6. MacDougall, C. D. *Hoaxes*, pp. 208-209. Second edition, Dover Publications, Inc., New York, 1958.
7. Mahler-Werfel, A.: *Mein Leben*, p. 45. Fischer, Frankfurt a. M. and Hamburg, 1963.
8. Nature: There are 44 articles and letters that appeared in "Nature" from 1919-1924, pertaining to the Kammerer controversy. For detailed references see Koestler's books.
9. Wendt, H.: *In Search of Adam*, pp. 364-370. Collier Books, New York, 1963.

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"Emmy Is Here and Working"

A promising new diagnostic tool is available to Oklahoma physicians and their patients. It is the EMI Scanner and probably the "First-Born" of forth-coming generations of such sophisticated devices.

From the British company that manufactured The Beatles' recordings comes a milestone in radiology, an X-ray scanner that allows neurosurgeons to view, as never before, the pathology of the brain. This breakthrough in electromagnetic research is the EMI Scanner, marketed by EMI Ltd., London. Oklahoma City's St. Anthony Hospital has the first "Emmy," as it is known, in Oklahoma.

Doctor Jerry Boles, chief of Radiology at St. Anthony calls the X-ray scanner, ". . . the beginning of a new era in radiology. The important feature of this relatively new technique is its ability to show the anatomy and pathology of the brain from a different angle than ever before." That is, from the inside of the skull.

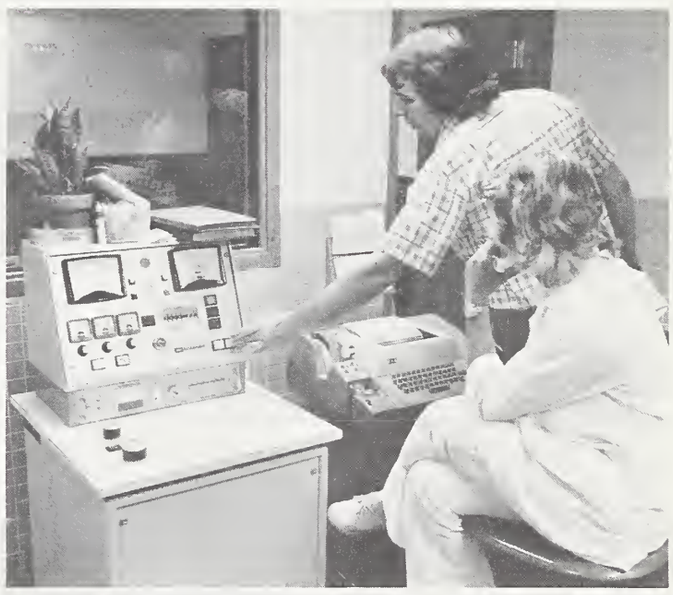
In order to be examined by the EMI, the subject lies on a flat table with his head resting in the scanner. Because the slightest move during the test can destroy the quality of results, the subjects must remain perfectly still. Occasionally younger patients or trauma victims are given a sedative to help them remain still during the test.

The scanner buzzes and clicks and revolves around the subject's head. After rotating 180 degrees, the machine stops. Then, there is silence while the EMI scanner's computer analyzes the data it received from two detection crystals in the scanner. Then on a small television screen, the computer begins sending pictures of different cross sections of the patient's skull and brain.

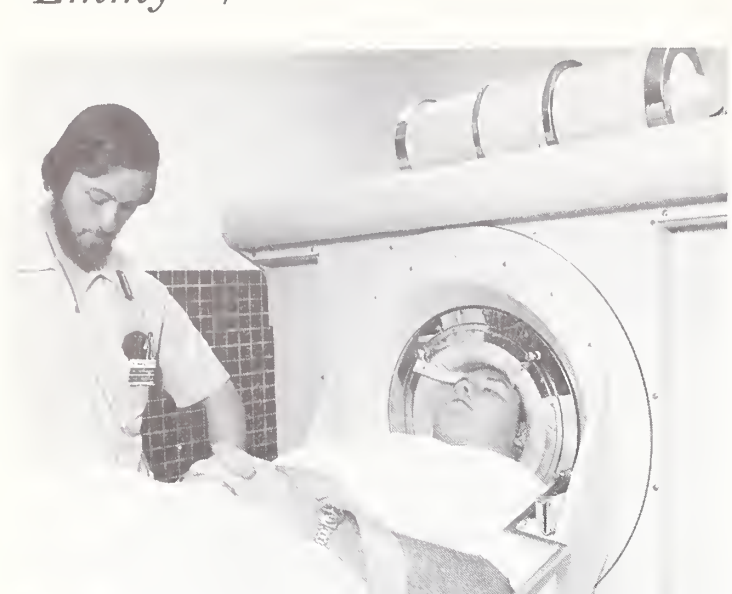
In one case, initial results showed a dark spot at the front of the skull, near the cerebral cortex. A contrast medium was then injected in the patient's vein and a second scan series was completed. The contrast medium enabled the EMI to demonstrate a tumor located at the back of the skull near midbrain. Within minutes, the cause of the patient's dizziness and occasional faintings had been diagnosed.

Upon receiving signals from the scanner, the computer is able to sort out the average densities in the brain from bone to fluid — within one to two percent accuracy. Physiciáns say that knowing the density of segments within the brain can help them determine to an accurate level the histology of the brain.

The appearance of the EMI Scanner is deceiving, considering the magnitude of the job it does. In one room is the scanner itself, a rather



At St. Anthony Hospital, the brain wave impulses sensed by the EMI Scanner, probing a patient's brain, are transmitted to a control unit, a teletype printer and a small oscilloscope screen. The radiologist then studies these records and analyzes, with the neurologist, the brain-mass lesions.



A patient is prepared for the EMI Scanner at St. Anthony Hospital. The patient's head rests in a cushioned cradle so that the EMI can scan brain-mass lesions. The scanning takes place utilizing a series of rotating planes and grid patterns.

large box with a rubber sheathed opening in which a patient's head comfortably floats above a cushion of water. Away from this device stands a bank of computer equipment, the heart of the scanner, where signals from the scanner are received, analyzed and translated into pictures.

Electromagnetic research has developed more rapidly than any other branch of medicine, including surgery and chemotherapy, during this century. And, development of new techniques, procedures and equipment such as the EMI Scanner point to a continuing surge in the use of electromagnetic radiation for diagnosis and therapy.

It has been barely 80 years since German physicist Wilhelm Conrad Roentgen discovered X-ray. Computer engineer Godfrey Hounsfeld developed the EMI Scanner to the point where some physicians now call it the "one" brain study that gives more information than all the others combined.

Doctor Boles calls the EMI Scanner the most sensitive method of interpreting brain tumors but also emphasizes the continuing need for other tests such as arteriograms, pneumoencephalograms and plain skull X-rays. However, he says, the advantages of the "Emmy" X-ray scanner are undeniable. The test is non-invasive, and oftentimes it is not even necessary to inject contrast material into the patient. When contrast material is necessary, it is injected into a vein rather than an artery. Doctor Boles says the test is thus less painful and less hazardous.

The brain X-ray scanner relies on the computer to analyze data it receives from X-ray pulses shot through a patient's head and detected by two crystals. The scanner revolves 180-degrees around the patient's head, emitting a thin, split X-ray beam. From this the computer gets detailed information about more than 25,000 separate segments of the brain, each sized 1.5 by 1.5 by 13mm. This technique, rather than bombarding the skull with a massive charge of X-ray, allows the computer to show any desired cross section of the brain, including views from immediately inside the cerebral cortex, at midbrain or the base.

The EMI Scanner's computer bank analyzes all parts of the brain by interpreting their affinity for absorbing or excluding X-rays. The sensitivity of the crystals that detect the amount of X-ray striking them, as well as the sophistication of the computer, combine to show portions of the brain not previously detected easily.

Doctor Boles says the computer doesn't lie about the picture of the brain it gets from an analysis of the average density of tissue and its propensity for X-ray absorption. "The difficulty comes," Dr. Boles says, "in the human trying to interpret what the scanner's computer is saying."

Interpretation is left to the radiologist in consultation with the referring physician, most often a neurologist. The pictures the computer draws of brain cross-sections are displayed on a television screen from which Polaroid pictures are taken for permanent reference.

Consultation, the human element in this diagnostic procedure, is a specialized job. Doctor Boles, as well as other radiologists and radiologic technologists at St. Anthony, has been trained in the operation of the EMI and the interpretation of its results.

A study recently conducted on a 12-year-old boy showed a neoplasm creating a blockage of the ventricular system. Further interpretation of the X-ray scan showed the neoplasm to be a cancerous tumor.

"From that one brain study, we got more information than we could have from the more common studies," Doctor Boles said. "In instances where we need fast results, and this

boy was suffering extreme headaches, I would say if we only could do one study, the EMI scan would be it."

The EMI Scanner produces detailed information about a specific region of the brain with relatively little radiation exposure. Statistics show the amount of radiation with the scan is much less than that developed during a plain skull series, an arteriogram or a pneumoencephalogram.

While physicians at St. Anthony are excited with the results of the tests they've made since the equipment arrived in March of 1975 at the rate of about 12 tests per day, they see that sophistication in radiology equipment is in its infancy.

As Doctor Boles said, "Technologically, we will be seeing within the next few years fantastic advances in radiology that will make this scanner look like a 'Model T.' One of these days, someone will come along with equipment that shows detail of the brain more quickly than 'Emmy.' In the meantime, this is the least costly, least painful and least dangerous procedure for studying the brain and its diseases than any other around." □

SEMINAR

ON

PLASTIC SURGERY

APRIL 24th, 1976

Presbyterian Hospital
OKLAHOMA CITY

A Seminar on Plastic Surgery, presented by the Oklahoma Society of Plastic Surgeons, Inc., and Presbyterian Hospital, will be held at 8:30 a.m.-12 noon, Saturday, April 24th, 1976 at Presbyterian Hospital in the Auditorium. The meeting is open to all physicians and allied-health professionals.

For more information, please contact

EDWARD A. SHADID, MD, Program Director
815 N.W. 12, Oklahoma City 73106, 232-7592.

Water Fluoridation and Dental Disease

Dental disease is the number one physical defect in this country. Ninety-five to ninety-eight percent of our citizens are affected with some form of dental disease during their lives, and only 40%, approximately, of the people in the United States have regular dental care. Therefore, there needs to be some way to help minimize this enormous problem.

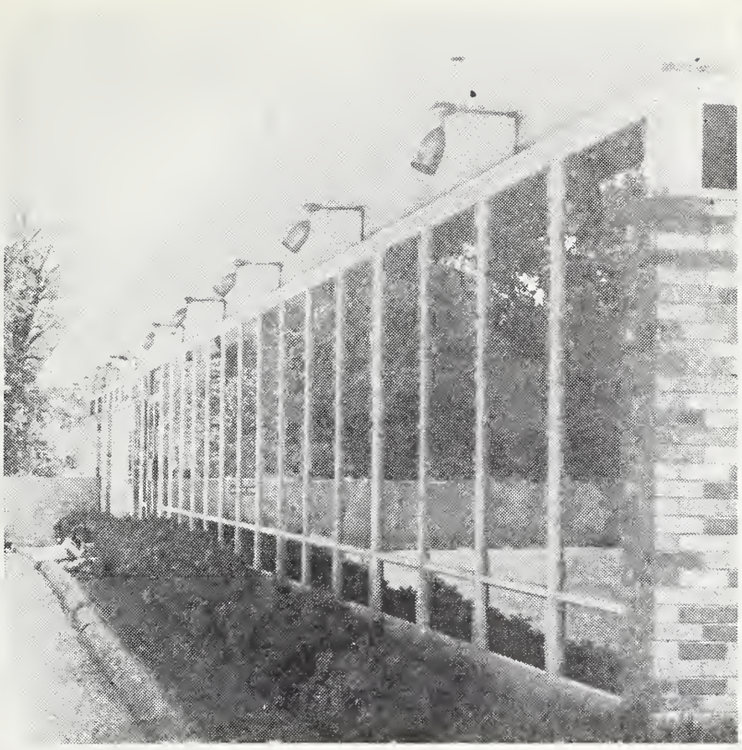
Fluoridating community water supplies at the optimum level of one part fluoride per million parts water, is the best, most effective, and least expensive method available to prevent dental disease. The cost per person per year is approximately 17 cents and with the continued intake of fluoridated water, dental decay can be reduced by as much as 60 percent. Through many years of research, fluoridation has not only been shown to be an effective preventive measure, but also has been proven to have no harmful effects to man. It has been endorsed by the American Dental Association, the American Medical Association, the US Public Health Service, and all other national organizations concerned with health. Also, laws requiring fluoridation have been enacted by nine states: Connecticut, Delaware, Georgia, Illinois, Michigan, Minnesota, Nebraska, Ohio, and South Dakota.

In the early 1950s, cities in Oklahoma began to fluoridate their community water supplies. Today, 33 cities in this State adjust the fluoride content of their water supplies to the optimum level and 23 additional cities purchase water from a fluoridated source. In addition, 183 communities have 0.6 parts per million or more of natural fluoride in their water supplies. Using this information, we can estimate that approximately 60% of Oklahoma's total population is currently receiving the benefits of fluoridated water. *Michael L. Morgan, DDS, Acting Chief, Dental Health Service, Oklahoma State Department of Health* □

News From The Oklahoma State Department of Health

COMMUNICABLE DISEASE IN OKLAHOMA FOR JANUARY, 1976

DISEASE	January 1976	January 1975	December 1975	Total To Date 1976	Total To Date 1975
Amebiasis	2	1	1	2	1
Brucellosis	—	1	3	—	1
Chickenpox	244	125	173	244	125
Encephalitis, Infectious	—	2	—	—	2
Gonorrhea (Use Form ODH-228)	1126	998	1228	1126	998
Hepatitis, A, B, Unspecified	261	101	70	261	101
Leptospirosis	—	—	—	—	—
Malaria	—	—	—	—	—
Meningococcal Infections	4	2	1	4	2
Meningitis, Aseptic	3	5	9	3	5
Mumps	77	17	56	77	17
Rabies in Animals	6	12	7	6	12
Rheumatic Fever	1	1	—	1	1
Rocky Mountain Spotted Fever	—	1	3	—	1
Rubella	13	42	9	13	42
Rubella, Congenital Syndrome	—	—	—	—	—
Rubeola	109	1	125	109	1
Salmonellosis	9	22	19	9	22
Shigellosis	15	103	39	15	103
Syphilis, Infectious (Use Form ODH-228)	13	13	8	13	13
Tetanus	—	—	—	—	—
Tuberculosis, New Active	25	17	28	25	17
Tularemia	—	—	—	—	—
Typhoid Fever	—	—	2	—	—
Whooping Cough	—	—	3	1	—





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GOVERNMENT AND MEDICINE

With Associate Executive Director David Bickham

BY RICHARD L. HESS
OSMA Director of Communications

As distressing as it may be, in many circles big government and medicine have become almost synonimous terms. In many cases, a physician cannot successfully practice medicine unless he fully understands government and its many regulations which directly affect his practice. Both the Oklahoma Legislature and the national Congress consider proposals almost every day which would have a sweeping effect on the medical profession. To survey this increasing relationship between medicine and government, *The Journal* conducted this interview with OSMA Associate Director David Bickham. Mr. Bickham has been in charge of legislative matters for over eight years, and is responsible for OSMA lobbying efforts.

JOURNAL: Mr. Bickham, it seems like more and more people look to government for solutions to their problems. Certainly on all levels, government has become more and more involved in the delivery of health care. In your opinion, why has this occurred? Is government equipped to handle all of the responsibilities now given it?

BICKHAM: As society develops more and more the attitude of corporate responsibility, rather than individual responsibility, it is natural that we look to government for the resolution of problems that before were handled at lower eschelons. Certainly, our experience over the past ten years indicates that state legislatures and the national congress are more inclined to attempt solutions to problems in the health field. In my opinion, this is a mistake; government should be the "court of last resort" for the resolution of social problems. The fact of the matter is, as we present our problems at higher government levels, we are abdicating our individual and local responsibilities and have in effect said, "We neither want to nor will we attempt to solve the problems ourselves."

As higher units of government write laws and regulations that deal with broad segments of the population, there is less individual attention given to demographic and local population characteristics. In other words, a national health law must apply equally to the citizens of New York and to the rural population of Oklahoma. We have recently seen how inequities result from this kind of national attention. It seems to me, we would be better off leaving problem-solving to state and local governments since it is obvious that the

"Government should be the 'court of last resort' for the resolution of social problems."

national government cannot write policy that is equally applicable to all parts of the nation.

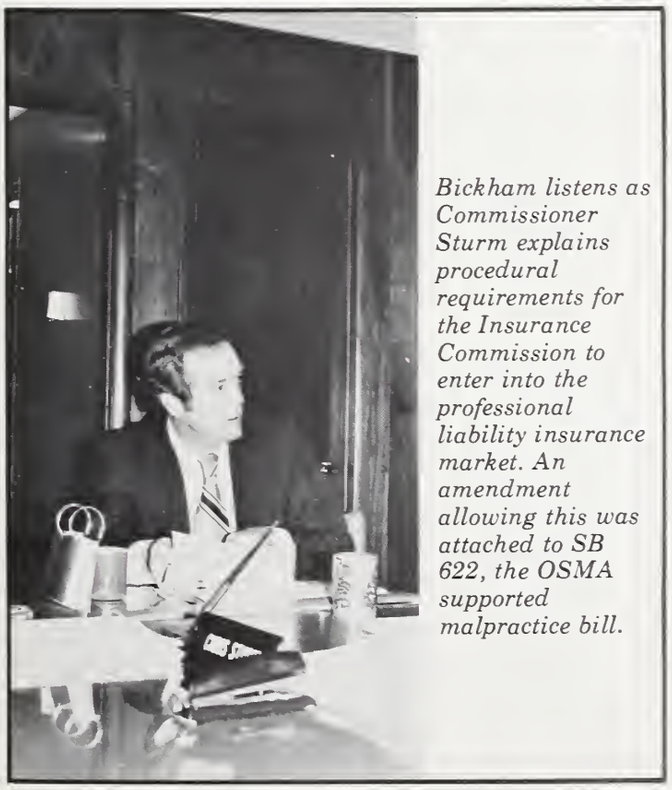
Ten years ago the association reviewed 10 to 15 medical bills introduced at the Oklahoma Legislature. At that time, the legislature only met every two years. Today, we review and take positions on 50-75 medical bills each year or more than 100 in each legislative session. The bills range from the conditions under which a physician can treat a minor to the type drug he can prescribe for his patient. Almost every area of health care is affected in some way by government action. While most doctors would like to ignore government intervention in their medical practice, few can. Those who do attempt to ignore the forms, the fee schedules, and the regulations, are occupied in fighting some other government encroachments.

JOURNAL: You are primarily involved with the Oklahoma Legislature so I will try to concentrate as much as possible on state issues. I would, however, like to survey as much as possible the future relationship between the federal government and the medical profession. Do you feel that there will necessarily be a growing relationship between the two, or is it possible that the trend toward government involvement in medicine may eventually be reversed?

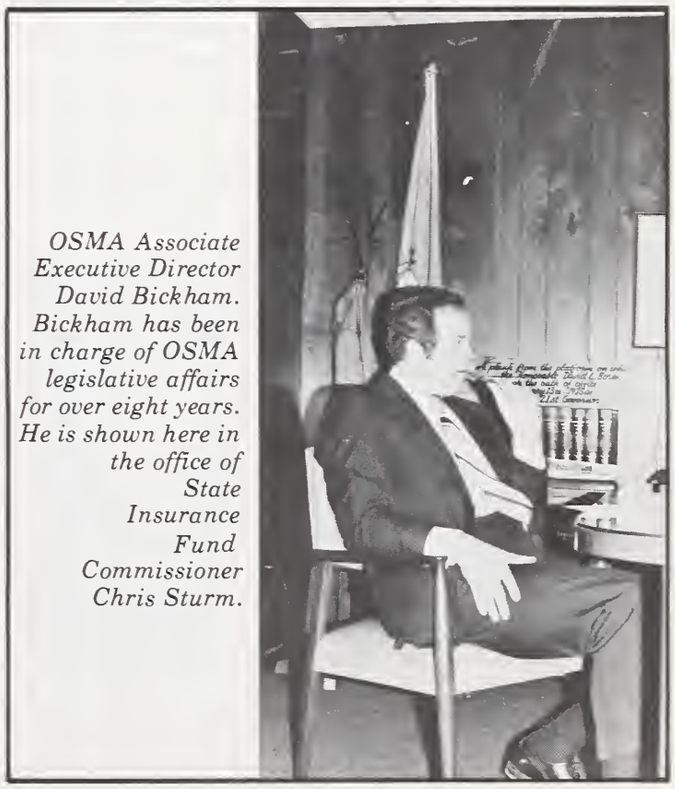
BICKHAM: Because of the increase in costs of medical services and the increasing demand by the general population for a part of those services to be paid for by government, I think it is obvious that there will be more federal health programs rather than less. The most critical issues are financing and availability, both of which politicians believe can be solved easier at the national level than at the state level. For some reason, people seem to think that the federal reservoir of funds is not directly related to the states and therefore, a federally financed health program has a lesser impact on their pocketbook than a state-financed program. In fact, the reverse is nearer the truth. We have seen the gigantic cost overruns in Medicare and the expansion of programs under Medicaid. It now appears that the federal solution to the problem is to combine the two in the name of efficiency and cost control, thereby excluding the states but most certainly increasing the taxes.

". . . we are abdicating our individual and local responsibilities and have in effect said, 'We neither want to nor will we attempt to solve the problems ourselves'."

JOURNAL: One issue now facing Congress is national health insurance. Do you feel a NHI



Bickham listens as Commissioner Sturm explains procedural requirements for the Insurance Commission to enter into the professional liability insurance market. An amendment allowing this was attached to SB 622, the OSMA supported malpractice bill.



OSMA Associate Executive Director David Bickham. Bickham has been in charge of OSMA legislative affairs for over eight years. He is shown here in the office of State Insurance Fund Commissioner Chris Sturm.

plan will be adopted in the near future? What in your opinion would be the biggest problem in administering such a program?

BICKHAM: I suppose that the inevitability of a national health insurance scheme has been predicted since its conception in the 40's, and I suppose that prognosticators almost universally would agree that sometime in the future, a NHI scheme will be adopted by the Congress. Unfortunately, many physicians and medical organizations have also adopted the "doctrine of inevitability" and now raise the question of what kind and when. I personally feel that the economy of the nation is not capable of accommodating another $100 billion a year social program, regardless of how it is financed. There are other problems this nation faces that, to me, are more important. The most notable being crime and poverty. This seems to be the concensus of most Americans, but oddly, not the feelings of the politicians.

I wish we could nationalize the Boren "sweep out the old guard" philosophy and replace our "doctrine of inevitability" politicians with some who would find new and worthwhile problems to solve.

The greatest problem in administering a national health insurance program is to decide who should and who should not receive the services. Studies have shown that the average American has an insatiable desire for good health which he connects with medical services. The cost, we know, is prohibitive and so the major problem will be "who is seen and who is not."

JOURNAL: Some people seem to feel that NHI would be one way to cope with the problems encountered in Medicare and Medicaid. Do you feel this is true or do you believe NHI would only compound those problems?

BICKHAM: Medicare and Medicaid were designed to solve specific problems. Medicare is an insurance program for the aged. Premiums are collected from the participants and pooled

"Almost every area of health care is affected in some way by government action."

to pay for the services rendered to the insured. The program is not actuarially sound, but it is an insurance program. Medicaid on the other hand, is a benefit program for the poor and indigent. It is financed through joint state-federal contributions and is not organized on the insurance principle. The problems in Medicare are created by the fact that the insured group of people, require, generally speaking, the most medical services. Collecting a sufficient premium to pay for these services, required by the participants, would drive the costs out of the range of most of those who now pay the premiums. Thus, there has to be federal subsidy. At the present time, states still have some prerogative in the benefits available in Medicaid programs, and those benefits are determined by the states financial ability to pay and the desire of the tax-paying citizenry to provide. Now, to replace Medicare and Medicaid with NHI would do nothing to solve any of the problems and it would eliminate the state participation and the state determination that exists presently. We would in effect merge existing problems into a bigger problem and lose one of the problem-solving partners that we have now — the state.

JOURNAL: Certainly on the state level, the malpractice insurance problem is the most important medically related issue now facing the Legislature. The OSMA supported malpractice bill, SB 622, has met with some stiff opposition and was virtually crippled in committee. What are its chances of passing? Do you feel there is any chance of restoring some of the more important sections which were stricken by the Senate Judiciary Committee?

BICKHAM: The Legislature will pass some



Bickham discusses professional liability bill with Representative David Craighead. Representative Craighead is an author of SB 622.

tort reform legislation that will aid in the malpractice situation. How extensive the reform will be is still questionable. While the malpractice crisis has received national publicity, Oklahoma doctors have not been faced with the extreme premiums nor have Oklahoma courts awarded excessive judgments. Hence, the Legislature fails to see the malpractice problems in "crisis proportions." Also, there is a general reluctance on the behalf of lawmakers to change radically laws that have been in place for a great number of years. While shortening the statutes of limitations, for example, seems a very reasonable reform measure to physicians, to legislators it is a legal overhaul that could potentially deny a justified claim. SB 622, even as originally proposed, was a fairly modest reform measure when compared to the actions taken in other state legislatures. But one has to remember that most of the states that have changed the laws or that have made significant reforms did so only after being faced with problems much more severe than what we have in our state.

JOURNAL: When the Senate Judiciary Committee first began considering this bill, several senators questioned the purpose of what they called "class legislation." Do you feel this is a just description of SB 622, and if you do, is the medical profession justified in seeking "class legislation?" Are there any particular problems in lobbying for this type of legislation?

BICKHAM: In the truest sense, every bill introduced at the Legislature is class

". . . I think it is obvious that there will be more federal health programs rather than less."

legislation. Just as every Legislature has a constituency, so does every bill. Perhaps a better word would be vested interest rather than class. Any class or vested interest legislation is justified if its end result is for the betterment of society as a whole. In the case of SB 622 the end result is to stabilize the malpractice insurance market and insure that physicians, hospitals, and health care providers can render their services in an atmosphere unencumbered by legal or financial hardships. In my opinion, that makes



Both Bickham and Sturm agree that the State should enter the malpractice insurance market only as a last resort. They discuss here under what circumstances this should happen.

the passage of this measure justifiable. The problem is trying to get the 150 lawmakers to understand the scope of the problem.

JOURNAL: As a registered lobbyist, how would you survey the mood of the Oklahoma Legislature toward the medical profession? Is it positive or negative? Has it gotten better or worse in recent years?

BICKHAM: The Oklahoma Legislature's attitude toward doctors and the medical profession is the same as the general public. Almost everyone loves their doctor, but many look with great disdain on the profession as a whole. This is a real enigma and extremely difficult to overcome. Generally, the public feels doctors make too much money and don't pay enough attention or really care about their patients. While our record in the Oklahoma Legislature has been pretty good, all things considered, I think we have a considerable amount of work to do in raising the overall image of the profession; particularly, in the area of political action. Until recent years few physicians were willing to become politically active in legislative campaigns and even now, too few are willing to donate time, money, and effort in getting candidates selected or elected. However, they are quick to criticize when lawmakers err. Physicians and their wives, because of their standing in communities, have a great potential in political action; potential that should be utilized more often and with greater consistency and enthusiasm. Also, we can't ignore the fact that our Legislature is predominantly Democratic and our profession is predominantly Republican. This, compounds our problems at the Capitol.

JOURNAL: I think you would agree that lobbyists as a whole have received some bad publicity during the past few years. Are there any particular steps or measures which you take to protect your credibility with the Oklahoma Legislature?

BICKHAM: Well, of course lobbyists have had a bad reputation in the public eye since the

> **". . . the economy of the nation is not capable of accommodating another $100 billion a year social program, regardless of how it is financed."**

Boss Tweed days and probably have received more attention in the past few years than they rightfully deserve because of activities in the national congress. In my eight years of working with the Legislature, I find that lobbyists are no different from any other professional group. There are good and bad. I personally hold the majority of lobbyists in high regard and most legislators do too. They almost form a fourth branch of government. Lawmakers are required to have knowledge of some 1,500 pieces of legislation each session. They have fairly limited staff resources and simply cannot be knowledgeable about the plethora of subjects with which they are faced. Lobbyists provide that extra dimension of resources which they need in making decisions. I have a fairly simple rule about lobbying. I never go to the Capitol unless it is absolutely necessary, and I only contact legislators when I feel that my particular information would be of value to them. And most importantly I always tell the truth.

JOURNAL: Because of its importance much of your time has been spent on malpractice legislation. However, a number of other bills are now pending at the Legislature which would affect the medical profession in one way or another. Would you briefly describe some of these bills? What position has the medical association taken on these bills?

BICKHAM: I mentioned earlier in the interview that there are almost 100 bills pending in the Capitol that affect medicine in some way. Most of these are not critical, but some, such as the repeal of anti-drug substitution laws, restrictions on drug sampling, abortion, and the right to provide health services to minors are significant legislative proposals.

Since the US Supreme Court decision abolishing the state's abortion laws, the legislature has made several attempts to restrict the conditions under which an abortion can be performed and the manner under which a patient can consent to the operation. There is a delicate balance between meeting the requirements of the Supreme Court ruling, good clinical practice, maintaining the rights of the individual and protecting the physician from criminal action. One segment of the legislature would like to severely restrict the abortion operation. They would go to the point of making it the public policy of the State of Oklahoma that abortions should not be performed. Another segment would like to see no law written, thereby permitting practitioners, hospitals, and the courts to interpret the Supreme Court ruling decision as they desire. Frankly, I don't know which is the best route. Since the Supreme Court ruling, we have not had broad scale abuse reported to the association. Nor has the Maternal and Child Health Division of the State Health Department received increased complaints. I think we could leave the law alone and depend upon the physicians and hospitals to develop the appropriate guidelines for performing abortions.

Another major issue pending that will have far reaching effects on a great number of physicians is the proposed reformation of Oklahoma Workmen's Compensation laws. The new act would provide for expert medical testimony in cases where physicians differed in their opinion as to the percentage of

> **". . . the Legislature fails to see the malpractice problems in 'crisis proportions'."**

impairment sustained by the injured employee. More importantly, doctors would be asked to rate the injury in terms of impairment rather than disability, a subjective determination which has substantial economic ramifications. Impairment, on the other hand, is a scientific measure and more in keeping with the physicians training and experience.

There is also a current controversy raging over the right of a physician to provide medical

services to minors without parental consent. The law passed in the last session leaves to the discretion of the physician the decision as to notification of parents about the treatment of minors.

The Sanity on Sex Organization feels that this provides for the wholesale prescribing of contraceptives to promiscuous teenagers and feels the law should be repealed.

Our Legislative Committee in the past has felt that the law had the necessary safeguards to protect the rights of the parents to know. The Committee feels that most physicians will consult with parents on medical matters involving their children. I will not be surprised if the Legislature amends the law to restrict the manner in which treatment can be rendered to minors. □

Oklahoma — Others Seek Legislative Reform

It's a sobering thought, but physicians in Oklahoma could face malpractice insurance premiums as high as $20,000 or $30,000 per year unless something is done quickly to turn around the trend toward higher judgments and more claims. Actually, insurance could conceivably climb higher because with the situation completely out-of-hand as it currently is, future premiums are only a guess. Another guess being tossed around more and more frequently is that unless some remedial steps are taken soon, insurance for doctors simply won't be available.

Across the country doctors are trying to interest their patients and legislators in the need for legislative reform. In many states some reform has been passed and now it's only a matter of waiting to see what, if any, effect it will have.

Oklahoma is no different from most other states. Insurance premiums have been rising for the past several years. So have the number of claims and the amount of the losses. This year the legislature has been asked to give Oklahoma doctors some relief from the malpractice insurance squeeze by passing legislation which hopefully would lead to a more manageable situation.

In nearly every piece of OSMA literature you are likely to see, Senate Bill 622 will be mentioned in one way or another. It is the OSMA endorsed malpractice bill pending before the legislature. Its future at this point is uncertain, but what is certain is that a rocky road lies ahead.



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In essence, SB 622 as it was originally written would do five things. It would provide the Board of Medical Examiners with better information about the number and size of malpractice claims; it would shorten the statute of limitations in Oklahoma and close the open-end period for filing claims in this state; it would allow the defense attorney to inform the jury about collateral sources of recovery available to the plaintiff; it would provide that anyone bringing suit against his doctor automatically waives his privileged status concerning information relevant to that particular case; and it would provide that the doctrine of res ipsa loquitur could only be applied if "expert testimony" first determined that the plaintiff suffered an injury, that the cause of the injury was solely in the control of the defendant, and that such an injury does not normally occur absent negligence.

That would have been the bill's effect as it was originally written. As a related story in this *Journal* points out, that is no longer the case as SB 622 has been riddled by committee amendments. Two sections were amended, and two others were deleted. Only the section giving the Board of Medical Examiners and leaders of the House and Senate better information about malpractice claims was left intact.

Some thought the OSMA had asked for radical changes — changes in longstanding laws. Others argued that the problem was not yet serious enough to go about asking for such changes. Still others questioned whether such "class legislation" was warranted.

What have other states done about this same problem?

Sixteen states have enacted reform aimed at modifying the statute of limitations or time for filing suits against physicians. Five states have passed laws clarifying the doctrine of res ipsa loquitur, and seven states have passed reform permitting evidence of collateral sources.

Below is a listing of reform passed in other states on these three issues.

What Other States Have Done

Statute of Limitations

California: One year from act or omission, or one year from discovery of the act or omission or injury, but no more than three years from the act or omission, except in case of failure to remove an unintentionally

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introduced foreign object or substance, in which case one year from discovery of the object or substance. An infant may sue within three years of the act or omission or prior to his eighth birthday whichever is longer.

Florida: Two years from discovery with a maximum of four years or a maximum of six years in case of a fraudulent concealment.

Indiana: Two years from the incident except that infants may sue until eighth birthday.

Iowa: Two years from discovery with maximum of six years, except for foreign object cases.

Louisiana: One year from discovery, with a maximum of three years.

Maryland: Three years from discovery, with maximum of five years, except for minors.

Massachusetts: Three years from incident, except that an infant has until his ninth birthday.

Michigan: Six months from discovery or two years from the incident, whichever later, except infants must sue within one year after reaching age twenty-one.

Nevada: Two years from discovery with a maximum of four years, except that an infant in cases of brain damage or birth defects has until he reaches ten years of age, and except for concealment.

New York: Two years and six months from the incident or last treatment, except one year from discovery of foreign object and except infants have until age ten.

North Dakota: Two years from discovery with a maximum of six years except for fraudulent concealment.

Ohio: One year from discovery with a maximum of four years, except infants may sue until age fourteen.

Oregon: Two years from discovery, with a maximum of five years, except for two years from discovery of fraudulent concealment.

South Dakota: Two years from discovery with a maximum of six years, except for fraudulent concealment.

Tennessee: One year from discovery with a maximum of three years, except for foreign object cases and fraudulent concealment.

Texas: Two years from the incident, except for an infant under six who has until his eighth birthday.

Collateral Sources of Recovery

California: Evidence of payments received by claimants from all collateral sources and evidence of remarriage of surviving spouse is admissible in evidence in mitigation of damages.

Idaho: If a physician or hospital carries required insurance, recovery of damages is limited to compensatory damages not previously paid or satisfied by any other persons or from any other sources.

Illinois: In assessing compensatory damages, consideration shall be given to all collateral sources of compensation received for payment of medical expenses, lost wages and other costs related to injuries.

Iowa: Damages awarded shall not include actual economic losses incurred or to be incurred to the extent that those losses are replaced or are indemnified by insurance or governmental, employment, service benefit programs or any other source except assets of the claimant or of the claimant's immediate family. This includes cost of medical care, rehabilitation services, custodial care, loss of services, and loss of earned income.

New York: In action to recover for cost of medical care, custodial care, rehabilitation services, loss of earnings or other economic loss, evidence is admissible that such cost was replaced or indemnified from collateral sources.

Ohio: Damages reduced by compensation received from any collateral source of medical or hospital care, custodial care, rehabilitation services, and loss of earned income, except insurance benefits or contract under which the cost was paid either by or for the claimant or his employer, or both, or by direct payments from the employer.

Tennessee: Damages for actual economic losses, such as cost of medical care, rehabilitation services, custodial care, loss of services, and loss of income only to the extent that such losses are not paid or payable by insurance provided by an employer, by social security, service benefits programs, unemployment benefits, or any other source other than assets of the claimant or the claimant's immediate family and insurance purchased in whole or in part privately and individually.

Res Ipsa Loquitur

California: Expert medical testimony is required to establish liability except in case of (1) foreign substance other than

medication or prosethetic device unintentionally left in body after surgery, (2) explosion or fire, (3) unintentional burn by heat, radiation or chemical, or (4) operation on wrong patient or wrong part of body.

Louisiana: Claimant has burden of proving lack of knowledge, skill and care by community and specialty standards, and of proving proximate cause, and injury alone does not raise presumption of negligence, but these provisions do not apply where the court fnds that res ipsa loquitur is applicable.

Nevada: Claimant must establish deviation from accepted standard of care and proximate cause by expert medical testimony, medical texts, or regulations of the health care facility, except in cases of (1) foreign objects, (2) explosion or fire, (3) unintended burns by heat, radiation or chemicals, (4) injury to a part of the body not involved in treatment, or (5) surgery performed on the wrong patient, or the wrong organ, limb or part of a patient's body.

Tennessee: Claimant must establish deviation from community standard of care and proximate cause by expert medical testimony of physician licensed in the state or an adjoining state, but the rule may be waived by the Court. Injury alone does not raise a presumption of negligence, but there is a rebuttable presumption of negligence where the instrumentality was in the exclusive control of the physician and the injury is ordinarily one which does not occur in the absence of negligence.

Washington: Claimant must establish departure from the accepted standard of care and proximate cause by a preponderance of the evidence. □

Anesthesia For Surgery Is American Discovery

A unique and highly important American contribution to medicine was the first use of ether as an anesthetic for surgery.

Prior to the 1840s surgery and dentistry were grim affairs. There was no dependable means of relieving pain during the operation. A stiff drink of strong alcoholic beverage was the surgeon's major anesthetic, and this did not

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actually prevent pain. The surgeon had to learn to work very fast to get it over with before the patient succumbed to shock or loss of blood, while his patient was strapped to the operating table. Surgery was a last resort, to be avoided if at all possible.

A young Georgia physician, Crawford W. Long of Jefferson, Georgia, was the first man to use ether for surgical anesthesia other than a dental procedure. On March 30th, 1842, Doctor Long used ether to remove two small tumors from the neck of a friend. The operation was successful and the patient suffered no pain.

Other pioneering work was underway in New England, and a report appeared in a Boston journal in 1846. The published report was promptly attacked as "quackery" and a lively exchange in the medical literature ensued for a time until the value of ether as an anesthetic was proved to the satisfaction of the medical community of the day.

One of the New Englanders who did the first experiments with ether, Doctor W. T. G. Morton, gave up his dental practice to devote full time to anesthesia, and is most likely the first professional anesthetist in American medicine.

From America the news spread to Europe in 1846 and the European surgeons were quick to take up the use of ether. Doctor Long early in his work began using ether to relieve the pains of childbirth. This precipitated a moral argument from clergymen and many physicians that childbirth pains were something that should be endured, but this eventually passed.

Oddly, ether first came to the attention of medical men through its use by sideshow entertainers. These men traveled about the country giving demonstrations by having men in the audience inhale ether and become pleasantly drunk. Ether parties became the vogue among young persons, who inhaled the substance at parties. Probably its first use as an anesthetic was in January, 1842, for a tooth extraction in Rochester, New York, when a young chemist who had been to some of the parties administered ether to a young woman dental patient.

It was after a public demonstration that Doctor Long got the idea of administering ether to a patient to operate without pain. Doctor Long had witnessed ether parties while a medical student at the University of Pennsylvania.

It was Doctor Oliver Wendell Holmes who suggested the name "anesthesia" for the pain-free condition and "anesthetic" for the substance that induced anesthesia.

At the founding meeting of the American Medical Association in Philadelphia in 1848 the subject of anesthesia was prominent on the scientific program. Physicians from throughout the United States learned of the discovery at the convention, and use of ether spread rapidly thereafter. Some surgeons still were reluctant to use ether in their operations, but the Committee on Surgery of that first AMA meeting declared that the benefits offset the risk. □

AMA To Establish Committee On Ethics

A National Advisory Committee on Ethics will be set up by the American Medical Association in an effort to focus attention on the moral and ethical challenges facing American institutions.

The AMA will help launch and finance the independent committee, to be headed by Fred T. Allen, chairman of the Pitney Bowes Corp., Stamford, Connecticut.

"Our purpose," said Allen in a February issue of American Medical News, "is to call attention to the importance of the ethical underpinnings of business, law, medicine, journalism, education — in fact, our whole society. Without a pervasive pattern of individual honesty a free society cannot function.

"We are in an early development stage, just starting to approach people to participate. When we have formed a broadly representative group, then I think we can talk more specifically about our objectives and the means to attain them."

AMA President Max H. Parrott, MD, and Raymond T. Holden, MD, chairman of the AMA Board of Trustees, said, "The AMA is initiating a National Advisory Committee on Ethics as a public service. The committee, its deliberations and its future recommendations, will be independent of us.

"Physicians certainly do not claim any exclusivity on ethical behavior or conduct. But medical codes of ethics go far back in history; they play an integral role in medical training and medical practice; and we therefore think it appropriate that physicians initiate a project of this sort." □



Thomas W. Lynn, Jr., MD

College of Medicine Dean Appointed

Doctor Thomas N. Lynn, Jr., a 1955 graduate of the University of Oklahoma College of Medicine, was named dean of that college in February by OU regents at their monthly meeting here.

Lynn had served as acting dean of the College of Medicine since July, 1974, following the resignation of former dean Robert M. Bird, MD. His appointment was recommended to the regents by OU President Paul F. Sharp and Doctor William G. Thurman, OU Health Sciences provost.

The action came after a university search committee worked for more than a year contacting and interviewing candidates for the job.

Lynn said, "I am gratified by the confidence placed in me through this appointment. I hope I can live up to that trust."

Sharp termed the appointment a "much-needed move that will strengthen the College of Medicine and our administration of it.

"Doctor Lynn has proven over the past 18 months, in a difficult position as an acting dean, that he is an extremely competent administrator. He has shown the kind of leadership that is needed in a dean," Sharp said.

HSC Provost William Thurman said Lynn's experience in developing family practice educational and residency programs "will be most helpful to the Health Sciences Center in meeting the state's needs for physician manpower."

"I look forward to working with him as a full dean to improve the College of Medicine to its maximum," Thurman said.

The new head of the medical school came to OU in July, 1959, as a chief resident in medicine and as a clinical assistant with the Department of Medicine.

In 1961, Lynn was appointed an instructor with the Department of Medicine and he became chairman of the Department of Family Practice and Community Medicine and Dentistry in 1969.

He currently is both a member of the Dean's Committee for the Oklahoma City Veterans Administration Hospital and a consultant in community medicine for the VA Hospital. He is medical director for the HSC Physician's Associate Program and is on the Residency Review Committee for General Preventive Medicine for the American Medical Association. Doctor Lynn also serves as a consultant in cardiology for Drumright Memorial Hospital.

From July, 1970 to June, 1972, he served as chief of staff of University Hospital.

Lynn did his internship in medicine at Barnes Hospital and Washington University School of Medicine, St. Louis, Missouri, and completed his residency training there and at the National Heart Institute, National Institutes of Health, Bethesda, Maryland. □

Vietnamese Doctors Need Aid

The Department of Medicine of the University of Oklahoma Health Sciences Center is conducting a program to prepare Vietnamese doctors for the Educational Commission for Foreign Medical Graduates examination. After passing this examination, the doctors will need one year of approved hospital training to obtain a medical license.

Many of these physicians are in desperate need of financial assistance. Sixty of them have indicated an interest in practicing in Oklahoma. If your community is interested in sponsoring one of these doctors in exchange for a commitment to practice in that community please write or call James F. Hammarsten, MD, Professor and Head, Department of Medicine, University of Oklahoma Health Sciences Center, P.O. Box 26901, Oklahoma City 73190, at 405 271-5555. □

HSA Appointments

If you have not seen a complete list of Governor Boren's appointments to Oklahoma's 30-member Health Systems Agency, it is shown below. There are 14 "health care providers" on the Board of Trustees and 16 consumers.

Subarea I (Tulsa)

Lloyd J. Verret, hospital administrator, Tulsa; Charles E. Christopher, optometrist, Tulsa; George Prothro, MD, director of the Tulsa City-County Health Department, Tulsa; J. D. Cheek, chairman of the Tulsa Area Health and Hospital Planning Council, Tulsa; Betty Drummond, homemaker, Pawhuska; and Donn Dodd, journalist and publisher, Claremore.

Subarea II (Oklahoma City)

Galen Robbins, MD, Oklahoma City; Terry Rice, director of planning and evaluation for the Indian Health Service, Oklahoma City; Neil Towner, administrative assistant for Blue Cross-Blue Shield, Oklahoma City; Aleece Clabes, juvenile court worker and homemaker, Midwest City; George McWhirter, mayor, Mustang; Joseph Jerkins, programming director of KTVY-TV, Oklahoma City; and Cleo Cross, homemaker, Norman.

Subarea III (Northeastern Oklahoma)

Dorothy Hall, nursing instructor, Miami; Fred Hoefer, VA hospital administrator, Muskogee; Jay Brown, county commissioner, Dewey; and Ken Caughman, community service director at Northeastern Oklahoma State University, Tahlequah.

Subarea IV (Southeastern Oklahoma)

Jeral Smart, nursing home operator, Wewoka; William G. Tanner, President of Oklahoma Baptist University, Shawnee; James Colclazier, Dean of Academic Affairs at Seminole Junior College, Seminole; Calvin Beames, retired Bureau of Indian Affairs agent, Kingston; and Max Minor, Oklahoma State University extension agent, McAlester.

Subarea V (Southwestern Oklahoma)

Geron W. Meeks, DO, Thomas; Peggy Risinger, hospital administrator, Altus; Ruby McMath, Communications Workers of America representative, Lawton; and Mrs. R. H. Powell, homemaker, Hollis.

Subarea VI (Northwestern Oklahoma)

Ortho Whiteneck, II, DDS, Enid; Jack Fetzer, MD, Woodward; Laurence Drake, farmer, Gate; and Claudia Hamilton, President of the State Hospital Volunteers Organization, Ponca City. □

Clinical Managers Form Group

Twenty-six persons associated in some area of medical group administration met on January 28th, 1976, at the headquarters of the Oklahoma State Medical Association and formally organized as the "Oklahoma Medical Group Management Association."

To be eligible for active membership in the association, a person must be a full-time employee who acts in a managerial capacity as a clinic manager or as an assistant clinic manager in a clinic composed of three or more licensed doctors of medicine whose employing clinic pays the person's salary and whose employing clinic is located within the boundaries of Oklahoma. Purpose of the organization is to improve the management techniques and capabilities of those designated persons working for medical groups in Oklahoma.

During the January meeting, the following officers were elected; James W. Loy, Administrator Chickasha Clinic, Inc., Chickasha, President; Arthur VandeLune, Radiology Associates, Oklahoma City, President-Elect; Lokey Johnson, Springer Clinic, Tulsa, Secretary-Treasurer.

The group plans to meet three times a year. Any person working in a managerial capacity for as few as three doctors may apply for membership. Questions pertaining to membership may be sent to any officer of the group or to the Oklahoma State Medical Association where they will be forwarded to the proper person. □

May 6th, 7th, 8th, 9th, 1976

OKLAHOMA MEDICAL SUMMIT '76

Lincoln Plaza Forum
Oklahoma City, Oklahoma

Weakened Malpractice Bill Reaches Senate

After the Senate Judiciary Committee's first hearing on Senate Bill 622, the OSMA's omnibus malpractice bill, bill author Senator Bob Funston commented, "I don't know whether to request a name change to Senate Bill 311 or to Senate Bill 1244 because I don't know if it's half the bill I came with or twice the bill."

Senator Funston's comment aptly describes what has happened to the OSMA supported piece of malpractice legislation in just two weeks.

Gone from the original version are two sections which OSMA officials thought were essential. Section 3 which provided that anyone bringing suit against his doctor automatically waived his privileged status. This would have done away with one of the inequities defense attorneys now face in court. Gone also is Section 4 which would have allowed the defense attorney to inform the jury about the plaintiff's collateral sources of recovery.

Section 5 dealing with the doctrine of res ipsa loquitur remains in the bill, but in a weakened form. Gone is the requirement of "expert testimony," the most important part of this section.

Changed from Section 2 is the one-and three-year statute of limitations. In its original version, all cases would have to be filed within one year of when the plaintiff knew or should have known of his alleged injury, and in no event could a case be filed three years after the occurrence. In the amended version the time limitations were changed to two and five years.

Weakened and diluted as it is, however, SB 622 did receive a DO PASS recommendation from the Judiciary Committee, so it is still alive. It will have to be amended, however, if physicians in Oklahoma are to receive the relief from the rising insurance rates which they need.

What will eventually happen to SB 622 once it reaches the floor of the Senate is not, of course, known. What is apparent, however, is that a tough battle lies ahead.

The bill's authors and OSMA officials had hoped to be able to pass SB 622 without amendments. Already two sections have been stricken, two have been weakened, and two additional sections have been added. SB 622 now also authorizes the state to enter into the malpractice insurance market should it become necessary, and it also gives the patient freer access to his medical records. More attempts to amend the bill, by both sides, are expected once it reaches the floor of the Senate.

OSMA Associate Executive Director David Bickham hopes to restore some of the bill's original punch once the entire Senate begins its consideration. It is also apparent, however, that the medical profession's adversaries will attempt to further weaken it.

Periodic reports on SB 622 will be provided in *OSMA MALPRACTICE UPDATE*. □

ORMP Schedules Conference

The Oklahoma Regional Medical Program (ORMP) has prepared a document which describes statewide criteria for providing health services in the diagnosis and treatment of specific diseases and/or injuries. The project was implemented at the request of the Oklahoma Health Planning Commission for possible use in the development of a statewide plan for health services.

The ORMP Committee on Program Assessment and Evaluation developed recommendations for guidelines and criteria to heart, stroke, cancer, end-stage kidney diseases, burns and perinatal services. The voluntary services of various physician members of (RAG) the Regional Advisory Group (ORMP) and other medical specialists in Oklahoma City and Tulsa were utilized by the committee in identifying and developing the criteria.

A seminar/hearing has been scheduled to obtain more input for validation of the documents to be held as follows:

Date: Friday, April 23, 1976

Time: 10:00 a.m. - 3:00 p.m.

Place: Holiday Inn Northwest
3535 N. W. 39th Expressway
Oklahoma City, Oklahoma

ORMP is cooperating with OSMA in securing participants for the seminar and also to circulate the criteria documents to specific specialty organizations and county medical societies prior to the meeting. □

Hemophilus Influenzae. Edited by Sarah H. W. Sell, and David T. Karzon. Nashville, Vanderbilt University Press, 1973, 325 pp, $15.00

This monograph contains the proceedings of a conference dealing with various aspects of *Hemophilus influenzae* held in April, 1972, at Vanderbilt University. There are some forty participants who are actively engaged in research in the biology of this complex group of microorganisms. This conference report is timely and offers the reader up-to-date versions of various aspects of this group of organisms, particularly H. influenzae, Type B.

The monograph is organized into ten sections, each of which contains several chapters written and illustrated by the investigators. They consist primarily of results of their research efforts. Each section is followed by a chapter containing the discussions of the presentations. The titles of the various chapters include: "The Natural History of Disease Due to H Influenzae", "Methods of Identification of Capsular Polysaccharides and Measurements of Their Antibodies," and "Relationship Between Antigens of Escherichia Coli Species and Hemophilus Influenzae, Type B." There are sections devoted to the epidemiology of *H. influenzae* meningitis and prospects for control of this disease by immunization.

This is a useful reference book, particularly for the specialist in medical microbiology, infectious disease, or vaccine development. *Harris D. Riley, Jr., MD*

Is My Baby Alright? By Virginia Apgar, MD, MPH, and Joan Beck. Trident Press, New York, 1972, 492 pp, $9.95.

This book is authored by a prominent physician who is a member of the medical staff of the National Foundation, and a journalist. Its purpose is to provide information to parents and members of health professions as to the causes, treatment, and prevention of prenatally and perinatally determined handicaps. About one-third of the book is devoted to a presentation of heredity, reproduction and intrauterine development which is pitched at about the right level to help the lay reader understand the potential causes of birth defects. The remainder of the book presents brief chapters on about twenty-five handicapping conditions, ranging from mental retardation and minimal brain dysfunction, to diabetes. These are punctuated by brief human interest stories that describe the situation of families of handicapped children and offer insight about the causes, diagnosis and treatment of the conditions.

The chief value of this book lies in information it contains for families of handicapped children, as well as for therapists, teachers and counselors who help them. This book represents a needed contribution. *Harris D. Riley, Jr., MD*

Square Pegs-Round Holes. By Harold B. Levy, MD, Little, Brown & Company, Boston, 1973, 250 pp, $7.50

The author has undertaken the ambitious task of directing his efforts to an important, but heterogenous audience consisting of parents, teachers and physicians. It deals with the learning-disabled child. As the author points out in regard to such children: who is he, how can you recognize him, and how you, as a parent, as a teacher, as a doctor, can help him.

As the author points out, a child with a learning disability usually has normal or superior intelligence, adequate vision and hearing, and is not psychologically disturbed. He usually comes from an environment that encourages learning, yet he does not learn. All too often his condition is misunderstood; he is called retarded or immature. He becomes embarrassed and frustrated by his inability to keep up with his class and is criticized by his teachers, tormented by his classmates, and punished by his parents. Part 1 deals with the concept of specific learning disabilities and traces the natural history of children with this disorder. Part 2 deals with the various common misconceptions that interfere with appropriate management and early intervention for these children. Part 3 outlines the basic components of a realistic learning disability team, namely the teacher, the parent, the physician, as well as the role of each member of the team.

This book is a positive contribution in an area which suffers from confusion. *Harris D. Riley, Jr., MD*

Blood Disease of Infants and Childhood. Carl H. Smith, MD, C. V. Mosby Company, St. Louis, 1972, 874 pp, 113 illustrations, $29.75.

This is the second edition of a standard reference in pediatric hematology. Doctor Smith died prior to the publication of the present edition and it is completed by Dennis Miller, MD, who succeeded Doctor Smith at the New York Hospital-Cornell Medical Center, as Director of the Division of Pediatric Hematology. This third edition adds additional data to this well regarded text. It has been made current through the addition of new information and references. As a reference work it is more complete than other volumes in pediatric hematology. The book will continue its wide appeal and usefulness to pediatric hematologists, but most practitioners may find it too detailed for practical use. *Harris D. Riley, Jr., MD*

Obstetrical and Perinatal Infections. Edited by David Charles, MD, and Maxwell Finland, MD, Philadelphia, Lea & Febiger 1973, 652 pp, $22.50

Since the late 1960's and early 1970's there has been a sharp upsurge in interest in perinatal biology. This has resulted from research efforts directed at increasing our understanding of maternal-fetal interactions. This book specifically addresses itself to the effect of infection on mother, fetus and infant. The material is well selected, clearly discussed, and well documented.

The volume is divided into three parts: Part 1, "The Fetus and Neonate," Part 2, "The Mother," and Part 3, "The Mother and Fetus." Like most books with multiple authors, there tends to be a certain unevenness. Certain selections, such as toxoplasmosis, are given a disproportionate amount of coverage, as compared to certain more common problems. The enormous subject of infections in the newborn is condensed into 40 pages, of which only about four deal with nursery-acquired disease.

The production standpoint of the book is considerably less than satisfactory. In many places the printing is illegible and type face is often irregular. This distracts from an otherwise useful book. *Harris D. Riley, Jr., MD*

The Critically Ill Child. Edited by Clement A. Smith, MD, W. B. Saunders Company, Philadelphia, 1972, 276 pp, $11.75

Doctor Clement Smith, recently retired as editor of *Pediatrics,* has brought together in this monograph a collection of essays about acute, manageable conditions which is rewritten and revised after publication in that journal. The attitudes and personality of each author come through in each essay. It is a useful monograph. *Harris D. Riley, Jr., MD*

Helping the Battered Child and His Family. By C. H. Kempe, MD, and R. E. Helfer, MD, J. B. Lippincott, Philadelphia, 1972. 313 pp. $8.50

This book may be considered a sequel to an important volume entitled, "The Battered Child," by Helfer & Kempe. The book opens with the justification of the term "battered child" which Kempe introduced in 1962. There are excellent chapters on the function of the courts, and that by Pollock and Steele on the approach to families in which a child has been abused. DeFrancis gives a thoughtful discussion on the problems of protective services, and Freidman's chapter on the importance of sustained follow-up of child abuse cases are both important. The focus of the volume is on the individual clinician's responsibility and ability to provide help to families in critical trouble. The contributors have succeeded in providing a sensible and practical guideline on child abuse management for physicians, nurses, social workers, law enforcement officials, attorneys, and judges. *Harris D. Riley, Jr., MD* □

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OMPAC

A lump in your throat, a knot in your stomach, a tear in your eye? A firm resolve to join your OMPAC or make your membership sustaining! This is the effect that this Masterpiece by Rex Kenyon, MD, had on me and I know that it will also stir you.

This poem was written by Rex and presented at an auxiliary workshop on legislation in Chicago, printed in the Political Stethoscope and has been entered in the Congressional Record by Congressman Jarman.

Read it again! Then join OMPAC and become a sustaining member and work for freedom.

Thank you, Doctor Kenyon. Auxiliary OMPAC Board Member, Martha Hendren.

THE GHOST OF FREEDOMS PAST

As a first class citizen, I'd rate
I've paid my taxes, pulled my weight,
Kept my conscience free from sin
Gone to church . . . least now and then.
With little leagues, I've learned to play
I've suffered hours of PTA,
I've paid my bills, observed the laws
And given to many a deserving cause.

But politics was not my dish
I'd rather golf, or hunt, or fish,
When I was asked by Mr. Pate
Would I support his candidate?
I said I'd sent a prior check
'Twas all a lie . . . but what the heck,
When called to work for Senator White
I said my schedule was too tight.

When precinct meetings rolled around
I said that I was leaving town,
When Party help was needed now
I said, "They're all crooks, anyhow".
Then when it came the time to vote
I spent the day out in my boat,
And life rolled on, day in day out
About my future, I'd no doubt.

Then one night while dreaming fast
I met the Ghost of Freedoms Past,
He led me from my snug, warm bed
To show me things that lay ahead.
He showed me faces, thin and bleak
On folk who toiled through endless week,
Meeting quotas, reaching goals
Living under strict controls.

He showed me children reared by State
Whose aim was to indoctrinate,
Empty churches stood forlorn
Worship outlawed, buildings torn.
The Halls of Congress sealed by rust
Ballot boxes collecting dust,
He showed me life where fear was norm
And all were clad in uniform.

He said when scientific tests were made
My kids had been assigned a trade,
Their lives a drudge, a menial chore
They could aspire to nothing more.
I'd been assigned . . . he then decreed
To clinics where there was a need,
I'd have a bed and board and clothes
With coupons to exchange for those.

For such I'd file a six-part claim
But sign my number, not my name,
And serve each day without complaint
The State had now become my Saint.
I pleaded then, "It can't be true
There must be something I can do,"
He sadly paused, and then he said
"My friend, Democracy is dead.

There's just no way for legal fights
The Courts are closed, and you've no rights,
You had a chance in seventy-five
To keep that marvelous thing alive.
You simply said 'The job's not mine'
Now this is nineteen-eighty-nine,
For all the world, you didn't care
While there were others waiting there.

To call your life style to a halt
You lost your freedoms by default,
You gave it up just inch by inch
Those activists . . . they had a cinch.
So here it is, no hope no joy
Don't cry on me . . . you blew it, boy!"
And just then, I awoke in sweat
But I recall that nightmare yet.

Of life, with which I could not cope
Devoid of dreams, devoid of hope,
Devoid of warmth, devoid of love
Devoid of guidance from above.
I saw the error of my ways
And I will spend my lasting days,
Preserving all that we can be
A nation proud and strong and free.

And like my forebears in the strife
I'll pledge my honor, fortune, life,
I'll hold my right to vote most dear
And with it, keep your future clear.
I'll work and give . . . support, oppose
This land won't fall to some of those,
Who want things I saw that night
Who feel that socialism's right.

This was my lesson. It will last.
Learned from the Ghost of Freedoms Past.

Rex Kenyon, MD
AMPAC Board of Directors

For a copy of this poem, suitable for framing, please write to AMPAC, Post Office Box 4449, Chicago, Illinois 60680.

It's still close to two months away, but the program for Oklahoma Medical Summit '76, May 6th-9th, is shaping up as one of the best ever presented. In all, over 3,000 persons are expected to take part in this the largest of all medical meetings in Oklahoma. This year's program is centered around a variety of interesting and informative activities, the cornerstone of which is the medical scientific sessions. Attendants can choose from a myriad of subjects, including a special series of "curbstone consultations," designed to give physicians the opportunity to consult with specialists in the fields of otorhinolaryngology, orthopedics, obstetrics and gynecology, and neurology. Socioeconomic topics such as PSRO and utilization review will also head the list of topics. A special program on sports medicine, featuring several experts from across the state, will also be held. Additionally, a close look at the malpractice insurance problem will be taken during a special session presented by medical malpractice defense attorneys for the Insurance Company of North America. Special activities have also been arranged for the ladies, along with a variety of other social events. A tennis and golf tournament will be held for the sports enthusiast. Plan on attending Oklahoma Medical Summit '76, May 6th-9th, at the Lincoln Plaza Forum in Oklahoma City.

The Oklahoma State Medical Association will hold its annual meeting April 9th-11th, 1976, at the Skirvin Plaza Hotel. This year's annual meeting will be held approximately one month before Oklahoma Medical Summit. The meeting will officially begin with a 3:30 p.m. meeting of the OSMA Board of Trustees, chaired by John A. McIntyre, MD. A reception and dinner for OSMA Trustees and their wives will be held that evening at 6:30. The opening session of the House of Delegates will commence at 9:30 a.m. on April 10th. Representing the AMA at this session will be Lowell H. Steen, MD, of Hammond, Indiana. Presiding will be S. N. Stone, MD, Speaker of the House. Reference Committee meetings will be held that afternoon. The closing session of the House of Delegates will begin at 9:30 a.m. on Sunday, April 11th. A dinner for OSMA Delegates, Auxiliary members, and their spouses will be held Saturday evening, April 10th.

The Oklahoma Senate has overwhelmingly approved and sent to the House the OSMA backed malpractice bill SB 622. The final vote on the measure was 42-1, with only Senator E. Melvin Porter (D-Oklahoma City) voting against the bill.

In effect, SB 622 was restored to its original form on the floor of the Senate. The statute of limitations was amended favorably to set a time limitation of two years from discovery or in **no event** more than three years from the date of the alleged incident. A section waiving the privileged status of information relevant to a malpractice lawsuit was approved. Under this section, the defense attorney would have to first apply to the court where the action was filed and if the court agreed that the requested information was relevant to the case it would be provided to the defense attorney. The section designed to clarify the res ipsa loquitur doctrine (the thing speaks for itself) was also amended favorably. It now provides that if the fact that the plaintiff suffered an injury solely caused by the defendant and not normally occurring absent negligence can not be established by information normally possessed by the "average person," then this fact would have to be established by "expert testimony." Only the section allowing the defendant to inform the jury about collateral sources of recovery available to the plaintiff could not be restored. This section was stricken by the Senate Judiciary Committee during its hearings. SB 622 will now go to the House of Representatives where it will first be considered by the House Insurance Committee. Oklahoma physicians are urged to contact their representatives and urge the support of this essential bill. For further information about this bill and the malpractice insurance problem, see future issues of *Malpractice Update.* □

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PREVENTIVE CARING

By now, each of us should have the message. We've heard it a thousand times. We've read volumes about it. We've had it presented to us in lectures, seminars, workshops, in countless entreaties from lawyers and insurance company representatives. It is presented in a variety of ways and in different words but it is, essentially, the first commandment of medical practice. It is a prescription for the prevention of medicine's current epidemic malady, malpractice litigation. The message is explicit and concise: Care about your patients and show them that you care.

Sounds simple enough, doesn't it? But it must be difficult or, at times impossible for many of us who are in the business of caring for patients to put into practice. Or perhaps we are too busy to show that we *do* care.

Our care is often evident only in the results of our applied technical skills. Unfortunately even a totally recovered patient can, with good reason, feel that he was neglected, abused and although cared *for,* not cared *about.* Patients thus may have ambivalent feelings about the physicians who "treated" them and later, when exposed to the resentful feelings of their friends and family who also felt uncared about, become convinced that they have been injured. Naturally, they seek retribution and yield to the pressures of wounded egos and exhausted financial resources. A "sue the bastards" attitude sprouts from the seeds of ineptness planted by the physician who might have achieved technical miracles but failed to show his patient and his patients' loved ones that he cared about them. Perhaps he failed to explain why he didn't prescribe a narcotic for the relief of pain or an antibiotic for a fever or an operation for a lump. Maybe he was too proud to call in a consultant or too busy to explain a complication or too embarrassed to say "I don't know." Or too impersonal to be a warm, responsive person.

It is not enough for us to possess and maintain technical skills and knowledge. It is not enough for us to be honest and thoroughly candid with our patients. It is not enough for us to be ethical and strictly professional in all our conduct. It is not enough for us to care for patients. We must care about them and more importantly, show them, in everything we do and say that we do care about them, as one friend cares about another friend.

Which brings us back to the message.

We must make friends of our patients, and become their friends. If we cannot be friends with certain patients, we should not attempt to be their physician. Real friends just don't sue each other. They make life — and the practice of medicine — beautiful. They care about each other . . . and they show it. *MRJ*

"Gratification and Frustration!"



The past year, serving as President of the OSMA, has been a busy one, filled with both gratification and frustration. The unified support from most of the membership has been phenomenal. It was truly exciting to sit in the Senate gallery with a large group of state physicians, our OSMA executive staff, OSMA secretaries, and many hospital administrators, and listen to the debate on our Senate bill 622. Senator Bob Funston did a superb job, presenting and amending the bill. Finally the moment of victory in the senate came, with only one dissenting vote. That, my friends, was real gratification!

Many thanks go to the Legislative committee, chaired by Doctor R. Barton Carl, and to our lobbyist Mr. David Bickham. The membership rallied with a united force, and the bill sailed through the senate, by a vote of 42 to 1. Thank all of you so very much. Senate bill 622 now goes to the House of Representatives. By the time this article is published, I hope the bill will have been signed into law.

Many frustrations have been encountered in dealing with the Federal bureaucracy. We have had so many promises, many of which were broken, or delayed endlessly. Many regulations have flowed from the Washington bureaucrats, designed to control every aspect of our lives. We are fighting many of those regulations, both on a state and national level. We must stem the tide of red tape before we lose all our individual freedoms.

Our Council on Public Policy, chaired by Doctor M. Joe Crosthwait, and our executive staff have worked all year to effect our resolution of non-participation in Utilization Review. Only recently was the final draft of the document sent to HEW in Washington for approval. Our Executive Director, Mr. Don Blair, has been the real leader and work horse on our Oklahoma plan. We hope to get this plan approved in the very near future.

The crowning blow came from the Washington bureaucrats on New Year's Eve, when the Federal Trade Commission attorneys charged the AMA with illegally restricting competition among physicians, by not permitting advertising. We quickly came out with a policy statement in opposition to the FTC. Many interviews on televison, radio, and newspapers were encountered. The following is a portion of the statement that I made to the press:

> The Oklahoma State Medical Association thinks it is ironic that the Federal Trade Commission, on the eve of the bicentennial year, would want to force the medical profession to step back 100 years into an era of hucksterism in medicine. One hundred years ago unqualified practitioners preyed on the public through false advertising, and to once again encourage this would be an unfortunate step backward into the past. The OSMA considers the FTC's complaint against the AMA's ethical constraints against advertising by physicians to be totally unfounded and without just cause.
>
> The OSMA agrees with the AMA's statement that, "Advertising by a professional is the very antithesis of professionalism." Health care is not a common good or commodity, and it should not be merchandised as such. Advertising by health practitioners would bring out the worst elements of a variety of practitioners who are licensed by the various states, but who cannot compete successfully on the merits of their professional skills.
>
> The OSMA believes very strongly that it should remain unethical for physicians and other respected professionals to advertise their services and fees: nothing good would come from this and much would be lost. Truth in advertising is a worthy goal which, unfortunately, has not been universally achieved. In Oklahoma a state law considers advertising by bona fide health professionals as being "unprofessional." We would hope that the Federal Trade Commission would not attempt to override the sovereignty of state government in this instance.

The AMA has taken a very firm stand against the FTC. More recently the following

(Continued on Page 150)

OSMA JOURNAL / scientific

When Is Antidiuretic Hormone Secretion Inappropriate?

W. O. SMITH, MD

When symptoms of water intoxication or a diminished serum sodium concentration are observed in a patient with the various predisposing conditions outlined, the syndrome of inappropriate secretion of ADH should be considered and the proper investigative procedures carried out. Water restriction and elimination of the underlying disorder where possible are ordinarily the proper therapeutic measures.

In order to understand the syndrome of inappropriate secretion of antidiuretic hormone (ADH) it is necessary to recall the normal regulation of ADH release from the posterior pituitary gland.

Almost 30 years ago Doctor E. B. Verney clearly demonstrated that increasing the osmotic pressure in the blood supplying the brain by the infusion of hypertonic substances into the carotid artery resulted in a release of ADH[7]. The increase in osmolality appears to trigger "osmoreceptors" in the brain, possibly in the hypothalmus, which in turn trigger posterior pituitary release of the hormone. This mechanism is so sensitive that an increase of no more than 5 mOsm/L. in blood flowing to the brain will induce ADH release.

There is also evidence that a decrease in volume in certain critical areas will induce the release of ADH. It is believed that there are at least two such "volume receptors," one located in the region or distribution of the carotid artery and the other in the left atrium. The afferent impulses from the carotid receptor are probably conducted centrally by the glossopharyngeal nerve and those from the left atrial receptor by the vagus nerve.

It is clear, therefore, that appropriate release of ADH occurs when blood osmolality rises or "effective" blood volume falls. "Effective" blood volume refers to that volume present in the sensor or receptor areas referred to above.

ADH effect on the nephron may be demonstrated by finding that the urine is hyperosmolar to the blood plasma. ADH accomplishes this final urine concentration by permitting water to pass more easily from collecting ducts across the basement membrane into the hypertonic interstitium of the renal medulla. However, since appreciable concentration of the urine may occur without ADH activity when the filtered load to the tubules is low, presumably due to increased exposure time, it must also be shown that glomerular filtration rate is not markedly impaired.

Then, the evidence for inappropriate secre-

tion of ADH includes a demonstration of ADH effect by showing:

1. Relative hypertonicity of the urine (compared to plasma)

and

2. No appreciable decrease of GFR (accept a normal BUN for this)

and demonstration that this is inappropriate by showing:

3. Decreased blood osmolality (rather than increased)

and

4. Normal or increased effective blood volume (this can only be approximated by total blood volume measurement).

Some workers in the field accept less stringent criteria for diagnosis of this syndrome than are outlined here.[1]

As a consequence of the expanded body fluid volume occasioned by the retention of water, secondary changes in body sodium occur. Hyponatremia results both from the hemodilution and from an actual increase in urinary sodium excretion. In fact, the clinician's attention is usually drawn to the possibility of inappropriate excretion of ADH by discovering hyponatremia.

There are at least three possible explanations for this paradoxic increased urinary sodium excretion: 1) a decrease in aldosterone release with the expanded volume 2) an increase in GFR; and 3) natruresis due to expanded volume not mediated by the adrenal—so-called—"3rd factor."

Measurements of aldosterone secretory rates and excretory rates in a number of these patients have been within normal limits. GFR is usually not significantly increased. It seems quite likely that the so-called "3rd factor" is primarily responsible for the inappropriate salt loss in this syndrome. "3rd factor" probably represents multiple factors decreasing sodium reabsorption in proximal tubules and perhaps other sites. It probably represents a humoral factor or factors but possibly physical and other factors are involved. A great deal of research is currently underway in many laboratories to identify this agent or agents.

TABLE I

CONDITIONS ASSOCIATED WITH INAPPROPRIATE SECRETION OF ADH

A. *Pulmonary diseases*
1. Bronchogenic carcinoma
2. Tuberculosis
3. Bacterial pneumonia
4. Lung abscess
5. Fungal infection
6. Assisted respiration

B. *Cerebral conditions*
1. Metastases
2. Trauma
3. Infarction
4. Ruptured aneurysm
5. Meningitis
6. Encephalitis

C. *Malignancies*
1. Bronchus
2. Pancreas
3. Duodenum
4. Prostate
5. Lymphosarcoma

D. *Drugs*
1. Sulfonylureas
2. Polymyxin B
3. Thiazide diuretics
4. Vincristine
5. Cyclophosphamide
6. Carbamazepine
7. Clofibrate
8. Fluphenazine

E. *Miscellaneous*
1. Porphyria
2. Myxedema
3. Guillain-Barré syndrome

ETIOLOGY

Inappropriate secretion of ADH has now been reported as a complication of a number of diseases (Table 1), particularly those involving the lungs and brain. It is now recognized as a relatively common disorder. The syndrome was reported by Schwartz et al in 1957 in two patients suffering from bronchogenic carcinoma[5]. Since that time many such cases have been reported; the carcinomas have usually been of the oat cell or anaplastic type. It is now realized that bronchogenic carcinomas as well as other malignancies have the capacity to manufacture humoral agents which manifest the same physiologic properties as normal endocrine hormones. Extracts made from the carcinomas of at least twelve such patients have demonstrated pronounced ADH-like activity on bioassay. This activity can be blocked with thioglycollate, suggesting that it possesses disulfide bonds like vasopressin. In one of these bioassays the supraopticohypophyseal system of the rats had been destroyed, ruling out induction of intrinsic release of ADH. Later Utiger and others demonstrated arginine vasopressin or a closely related peptide in such tumor extracts by radio-immuno-assay[6]. Resection of these tumors correct the abnormal

---

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water retention unless metastases are present. These studies strongly suggest that an antidiuretic substance is elaborated from the carcinoma itself in these patients.

Pulmonary tuberculosis has been known to be associated with hyponatremia since 1938[8]. More recent evidence has revealed that many of these patients demonstrate the criteria for the syndrome of inappropriate secretion of ADH (SIADH). In most instances the disease is obviously not of sufficient extent to disturb intrathoracic volume receptors. It is believed that there is a primary reduction of intracellular osmolality in the receptor cells with a subsequent shift of water to the extracellular space leading to both increased thirst and increased secretion of ADH. This hypothesis, however, is not proven.

It has been adequately shown that positive pressure respiration is accompanied by antidiuresis in dogs, rats and man which appears to be due to increased release of ADH. Several patients with chronic obstructive lung disease have been observed to develop the picture of SIADH. These patients were also on positive pressure respiration when the syndrome developed. The patients showed a remission of abnormalities when the positive pressure breathing was discontinued. Poor filling of the left atrium resulting from diminished pulmonary venous flow is presumably responsible.

Other pulmonary infections, such as various types of pyogenic pneumonia, have subsequently been recognized as a cause of this syndrome.

For many years it has been recognized that central nervous system disorders may be attended by hyponatremia. This has been referred to as cerebral salt wasting or cerebral hyponatremia. It now seems likely that many, if not all, of these patients have SIADH. Most of these patients have metastatic disease, trauma or infections of the brain. Although it might be supposed that the excess ADH in these instances is a result of direct irritation of receptor centers in the brain or of the posterior pituitary itself, location of the lesions in some cases does not support this view.

A number of drugs listed in Table I have been reported as leading to SIADH.

Case reports have appeared linking SIADH with such diverse conditions as porphyria, myxedema, Guillain-Barré syndrome and assisted respiration. One patient has been reported who showed only an elevated blood amylase and the only pathologic finding in another was an abnormal EEG.

CLINICAL MANIFESTATIONS

The clinical manifestations resulting from this syndrome are quite variable (Table II). Clinical findings associated with the underlying disorder may be obvious as in advanced pulmonary tuberculosis, or unimpressive as in some instances of small, peripheral pulmonary carcinomas.

If the serum sodium concentration is above 125 mEq/l symptoms relating to SIADH are usually not noted. With levels below 115 mEq/l most patients manifest at least some evidence of water intoxication on careful observation. Confusion, disorientation, and headache are common. Nausea and vomiting may occur. Some patients may develop convulsions and coma. If a weight record is available on the patient the expanded body fluid volume is likely to be reflected in some acute weight gain, although overt edema is not likely to be present. After the retention of only a few liters of water there appears to be an escape phenomenon from a constant, excessive vasopressin stimulus, whether endogenous or exogenous with apparently new regulatory control settings developing[3]. This new "steady state" may apply to urinary sodium excretion also. The mechanism for this escape from vasopressin effect is unknown at present.

This condition must be differentiated from a large number of disorders resulting in hyponatremia, particularly those in which the hyponatremia is principally due to water retention, ie, dilution. For example, if the patient also has decompensation of the heart, liver, or kidneys another mechanism for the hyponatremia is more likely. Patients with adrenal failure usually have volume depletion rather than excess, hence should not be confused with this syndrome.

The laboratory tests which are important in

TABLE II

CLINICAL MANIFESTATIONS OF INAPPROPRIATE SECRETION OF ADH

Confusion
Disorientation
Headache
Nausea and vomiting
Convulsions
Coma
Weight gain

TABLE III

LABORATORY FINDINGS IN INAPPROPRIATE SECRETION OF ADH

Consistent ↑ in urine osmolality relative to serum
↓ Serum osmolality
Normal BUN
Normal or ↑ blood volume
↓ Serum sodium
↑ Urinary sodium

the diagnosis of SIADH are listed in Table III. As previously discussed, they are directed at proving that ADH effect exists and that it is inappropriate to the physiologic circumstances. A recent paper stresses that the blood levels of ADH measured by radioimmunoassay are not suppressed by water loading as would normally be expected[4].

THERAPY

From the foregoing discussion the proper therapy for this syndrome should be clear, namely, restriction of water intake. The amount of water allowed should be adjusted to the response of the individual patient. In general, a 24-hour fluid intake of less than 1,000 ml will be required. This measure will correct not only the element of dilution but, secondarily, the abnormal urinary loss of sodium as well, since the body fluid volume expansion will be controlled.

Since total body sodium may be in fact diminished from urinary loss, repletion of this cation may be necessary. However, this should not be attempted until volume is reduced by water restriction; otherwise pulmonary edema may result. Sodium repletion can then be accomplished by oral replacement in most instances.

In severe instances the use of hypertonic saline may be justified in non-cardiac patients. Recently therapy with potent diuretic agents such as furosemide, with careful monitoring and replacement of electrolytes, has been advocated in severe cases.[2] Furosemide eliminates concentrating ability, leading to the production of isotonic or slightly hypotonic urine and the loss of large amounts of sodium. While using this diuretic, hypertonic saline replacement can be undertaken without fear of excessive volume expansion.

Where possible the underlying disease should, of course, be treated in the proper manner. For example, resection of a localized pulmonary carcinoma or correction of myxedema by replacement therapy may result in disappearance of the syndrome of SIADH. □

ACKNOWLEDGEMENT

I should like to extend my sincere appreciation to Doctor Robert D. Lindeman for his review, criticisms, and most helpful suggestions in the preparation of this manuscript.

REFERENCES

1. Bartter, F. C., Schwartz, W. B.: The syndrome of inappropriate secretion of antidiuretic hormone. Am. J. Med. **42:**790-806, 1967.
2. Hantman, D., Rossier, B., Zohlman, R., Schrier, R.: Rapid correction of hyponatremia in the syndrome of inappropriate secretion of antidiuretic hormone. Ann. Int. Med. **78:**870-875, 1973.
3. Jaenike, J. R., Waterhouse, C.: The renal response to sustained administration of vasopressin and water in man. J. Clin. Endocrinol. **21:**231-242, 1961.
4. Miller, M., Moses, A. M.: Urinary antidiuretic hormone in polyuric disorders and in inappropriate ADH syndrome. Ann. Int. Med. **77:**715-721, 1972.
5. Schwartz, W. B., Bennett, W., Curelop, S., Bartter, F. C.: A syndrome of renal sodium loss and hyponatremia probably resulting from inappropriate secretion of antidiuretic hormone. Am. J. Med. **23:**529-542, 1957.
6. Utiger, R. D.: Inappropriate antidiuresis and carcinoma of the lung: detection of arginine vasopressin in tumor extracts by immunoassay. J. Clin. Endocrinol. **26:**970-974, 1966.
7. Verney, E. B.: The antidiuretic hormone and the factors which determine its release. Proc. R. Soc. Lond. (Biol.) **135:**25-106, 1947.
8. Winkler, A. W., Crankshaw, O. F.: Chloride depletion in conditions other than Addison's disease. J. Clin. Invest. **17:**1-6, 1938.

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A Pediatric Approach To Learning Disabilities

ROBERT W. BLOCK, MD

The child with learning disabilities deserves coordinated evaluation, management and followup, but we cannot mislabel all school difficulties as learning disabilities.

Going to school represents the major activity of childhood after the age of five or six years; and achievement in the classroom continues to be a major measure of success in our society. Consequently, the child who fails in school is often seen as failing in life. He becomes sensitized to failure with a subsequent loss of self-confidence and an increasing fear of failure, to the point of expecting to fail, or of withdrawing from the educational system.[1-3]

Pediatricians and family practitioners need to take a comprehensive approach with school-age patients. We need to understand more about learning disabilities and involve ourselves with the problem to prevent our patients' frustration and failure.

The pediatric approach to learning disabilities begins with identification of young childen who might later develop problems in school. Selected precursors known to lead to school problems are listed in Table I. These factors can be easily identified in a preschool history. Table II illustrates some prerequisite skills necessary for success in school. A fifteen-to

TABLE I
PRECURSORS OF SCHOOL FAILURE

1. Delayed or Inarticulate Speech
2. Small-for-Gestational-Age Infant, Ex-prematures, especially males
3. Hyperkinesis
4. Family History of Reading Problem
5. Developmental Lag
6. Poor Early Nutrition

— Fidone[1]

TABLE II
PREREQUISITES FOR STARTING SCHOOL

1. Intelligible to Teacher, Classmates
2. Follow Three-Command Directions
3. Listen to Story and Retell
4. Copy Circle, Square, Triangle, Cross
5. Sit Still for 15 Minutes
6. Accept Limits; Tolerate Some Frustration and Delayed Gratification

— Gofman & Allmond[2]

TABLE III
EARLY LEARNING

1. Listens to Music, Sings
2. Nursery Rhymes
3. Knows Phone Number, Address
4. Tricycle and Bicycle Riding
5. Skips Rope
6. Plays Tag, Knows Rules
7. Plays Kickball, Marbles
8. Does Puzzles
9. Helps in Garden
10. Runs Errands
11. Plays "School"
12. Watches TV, Rides Quietly in Car, Attends During Family Meals

twenty-minute examination which can include the usual school physical exam is sufficient for evaluation of these factors.

By the time a child is in school and diagnosed as learning disabled, he has already, in prior years, learned a great deal. Evaluating the child's performance in the items listed in Table III gives us an idea of preschool learning, some of which is quite complex. Item 12, for example, gives a gross estimate of activity level and frustration tolerance. A helpful checklist for office assessment of personality and developmental factors is illustrated in Table IV.

If a child is already in first or second grade and is identified by the school as learning disabled, what then? This is an area where some far-reaching questions are being asked. After the early work by Strauss and his contemporaries in the 1940's and 1950's, a good deal of discussion and controversy about "minimal brain dysfunction" began.[4] Parents recognized published patterns that fit their children and formed groups like the Association for Children with Learning Disabilities. Government recognized its responsibility and formed the United States Office of Education and the 91st Congress passed the Developmental Disabilities Act. When tax dollars are expended, cumbersome detail sometimes develops. For example: (1) How do we establish eligibility for learning disability programs? (2) What are the criteria for diagnosis? (3) What kinds of assistance can be offered? We have become locked into a system that requires labels. Occasionally labeling can lead to difficulties in obtaining appropriate educational assistance for some children.

Case 1: M.S. was a nine-year-old boy moving from Kansas to Virginia. The new school system required a diagnosis of Minimal Cerebral Dysfunction (MCD) for placement in special education classes. Appropriate diagnoses for M.S. were cerebral palsy with paraparesis, mixed discipline signals from an Army-career-officer-"my son is not crippled" father, and an inconsistent educational course due to three moves in three grades. However, I certified that he had MCD so he could obtain the special help he needed in school. The special school also required that he be diagnosed as hyperactive.

What does hyperactivity mean? I like to think in terms of distractability, inattentiveness, purposeless activity and goal-defeating behavior. I do not consider "hyperactive" the normally curious three-year-old. I do not consider "hyperactive" the four or five-year-old who knows only inconsistent limits. I do not consider "hyperactive" a child in a classroom of thirty who has finished his work, gets bored and bothers others. Why is activity level so important? Roger Freeman[5] in 1972 made the following comment: "There are indeed children who learn poorly and who may also have behavioral problems or developmental deviations. However, we may be doing them a disservice by isolating only one characteristic (hyperactivity) which they have in common,

TABLE IV
CHECKLIST FOR SCHOOL READINESS

1. Language Development
2. Gross and Fine Motor Development
3. Personal-Social Development
4. Attentiveness
5. Curiosity and Eagerness to Learn (Motivation)
6. Competitiveness
7. Diligence
8. Frustration Tolerance
9. Maturity
10. Response to Discipline

Since his graduation from The University of Pennsylvania School of Medicine in 1969, Robert W. Block, MD, has been certified by the American Board of Pediatrics. At present he is Assistant Professor of Pediatrics, Department of Pediatrics, Tulsa Medical College. Doctor Block is a Fellow of the American Academy of Pediatrics and a member of the Ambulatory Pediatric Association.

TABLE V

TOOLS FOR EVALUATING LEARNING DISABILITIES

1. History: Perinatal, Infancy, Toddler, Traditional
2. Complete Physical
3. Special Neurological
4. Coordinated Psychological Tests
5. Speech/Hearing/Vision
6. Education Summary

prescribing for this particular difficulty and neglecting their differences." I have the feeling that many physicians are pressured into treating a symptom, easily recognized by themselves, teachers or parents, much the same as they are often pressured about prescribing antibiotics for the symptom of fever without fully analyzing the underlying problem. The pediatric approach is to differentiate true primary hyperkinesis from secondary causes and to treat only when appropriate, and to follow up.

Once we have identified children who are not learning or who are at risk of not learning, we proceed to an evaluation. (Table V) I believe in a team approach and I think that the physician should be the captain of the team.

Perhaps the most important part of the pediatric approach to learning disabilities is reviewing the evaluation, findings and recommendations with the parents, child, and the child's teachers. Herein lies the reason for the physician to be the team captain. The parents need to hear one voice to avoid confusing differences in interpretation. Their doctor is in a position to know about, and interpret the meaning of home situations, illnesses, child-rearing practices and the like, all of which affect learning.

Case 2: J. B. was a nine-year-old boy referred for MCD — his teacher's diagnosis — because he rather acutely began to perform poorly in third grade after a good beginning. The history from his mother was very unrewarding. Neither one of us could think of any reasons for poor performance. While talking with J. B. I was impressed with his eager affect, maturity and apparent desire to do well in school. It became apparent that he had something on his mind he needed desperately to talk about, but was afraid. Finally in tears he "confessed" that he still wet his bed. His mother, of course, had known but was sworn to secrecy and had kept her promise. J. B. was so compulsively concerned with enuresis that he closed out all other things including school. Once we talked about the problem (was he ever surprised to learn he was not the only boy alive who wet his bed!) his school performance returned to normal — and, incidentally, his enuresis ceased.

This case illustrates how a physician, concerned with the child as a total human being, can be alert to multi-factorial problems and hence makes an appropriate leader for a multidisciplinary team.

Parents need time to ask about the things they are reading in lay publications. Is the brain really "damaged"? What about food coloring and artificial additives? Does coffee really help? What about milk allergy? A review session with parents is also an opportune time to introduce a program to be used at home. I am a believer in behavior modification, if it is repeatedly tailored to the individual need. I explain how to talk with the child, simply and directly and while touching the child, which if nothing else keeps him from running away! I encourage rewarding steps toward successful completion of a goal and minimizing failures. That does not mean lax discipline. Quite the contrary, reasonable, fair but firm limits with consistent enforcement are stressed. What about homework? Parents can help and should be involved and interested in what is happening in school, but they should not become substitute teachers. I have found that some of the best "tutors" are high school juniors and seniors, completely untrained, who eagerly come by two or three times a week for an hour of study with the grade school child. I have parents tell these students only that their child needs a little extra help and they can try any non-punitive method to help the child learn. Results are usually encouraging and this part of the learning experience becomes fun.

The children have every right to know why everyone is paying so much attention to them. They need reassurance that tests indicate they are not "dumb" or "crazy" as their friends keep telling them, that they will be able to learn in time and that they will have new friends who will help them to learn and make school a better place. I am consistently reminding people who deal with children to talk *with* and not *at* children, and I am constantly amazed at what I learn when I practice what I preach. One of my guidelines for judging the effectiveness of medi-

cation, for example, is the verbal response of the child who can tell me if it is helping.

A direct conversation with the child's teacher is essential for a complete review. The school needs the results and interpretations of all evaluations.

Careful *followup* is of paramount importance with whatever treatment method is chosen, especially if it involves medication. This includes a periodic talk with parent and child as well as with the teacher. To get involved in learning disabilities, one must be willing to commit oneself to taking time for continuing re-evaluation.

The last aspect of the pediatric approach is community involvement. Proper understanding of learning disabilities by doctors, teachers and parents can lead to more appropriate referral, better treatment and education and consequently less time spent inappropriately. Community involvement means first of all involvement with the schools. We forget at times that "school" isn't just a red brick building but is a group of professional educators often expected to perform miracles. We should become familiar with the educational system in our cities and we should talk with specific people involved in our patients' education. We need to understand our educators' tolerance of variations of normal in their classrooms and their standards for academic and social achievement. We need to know how the school and the lay community view special education and the availability of and methods for special education in our cities.

Schools are increasingly being criticized for their inability to meet children's individual educational needs. Sometimes unrealistic achievement goals are set. We forget there is an IQ continuum — that not every child will learn easily and perform well even if given every opportunity to do so. Educators, parents and doctors have all, at times, forgotten the meaning of an average IQ. A child with *average* intelligence and average behavior is not going to pass easily from grade to grade without a struggle, and he may not always manifest excellent behavior. No known treatment will change an IQ of 90 into 120. Teachers and parents need to be reminded that an average child might be helped to learn in an average fashion but we are not going to create a straight A student. An average child is not "learning disabled" only because he fails to make A's or occasionally acts up in class.

Community involvement will help a physician acquire the necessary information to make recommendations that are consistent with what can actually be done in the community's schools. Recommending a learning disability class isn't much good if none is available and if it isn't, the physician should see what he can do to help insure adequate education for his patients.

SUMMARY

The pediatric approach to learning disabilities begins with identification of children at risk. Older children who meet accepted definitions of learning disabilities may need evaluation by a multidisciplinary team. The physician is responsible for identifying behavior or emotional problems, physical disease, mental retardation, etc. as well as true learning disabilities. History, physical exam, neurological exam and definition of the problem are medical responsibilities. Obviously treatment, especially if it involves medication, is a medical responsibility. Followup with constant review and revision is mandatory. Community involvement is also vitally important. In spite of mounting concern that MCD or learning disability is a figment of the imagination of distraught teachers and doctors, I believe it is a real entity. It may defy definition but it will not defy comprehensive, cooperative attention by all of us who are concerned with children. □

ACKNOWLEDGMENT

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This paper was presented in an expanded version at the Annual Tulsa Pediatric Colloquy, October 2nd, 1975.

REFERENCES

1. Fidone, G. B.: Recognizing the Precursors of Failure in School. Clin. Ped. **14(8):**768, 1975.
2. Gofman, H. and Allmond, B.: Learning and Language Disorders in Children. Part I. Curr. Prob. Ped. 1:10, 1971.
3. Gofman, H. and Allmond, B.: Learning and Language Disorders in Children. Part II. Curr. Prob. Ped. 1:11, 1971.
4. Strother, C. R.: Minimal Cerebral Dysfunction: A Historical Overview. Ann. N.Y.A.S. **205:**6, 1971.
5. Freeman, R. D.: The Drug Treatment of Learning Disorders: Continuing Confusion. J. Ped. **81**(1):112, 1972.

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A Comparison Of Physician Responses To Child Abuse, Tulsa County, Oklahoma; 1969 and 1974

MARJORIE YOUNG, MSW

Physicians surveyed prior to a Child Abuse Registry and five years afterwards, have stable perspectives toward child abuse and are utilizing the registry as predicted.

It has been estimated that there are about 450,000 child abuse cases reported each year in the United States and that the number of unreported cases may be three or four times as many. Frequently, it is the physician who is in front line contact with this mayhem of our children. The attitudes and behavior of the doctor in regard to the abused child and the child abuser, therefore, are of critical importance to any effort to cope with child abuse. Whether the problem is defined as social, psychological, criminal or whatever, it remains a medical problem as well — for it is the physician who is often the one called upon to do something about it.

A strategy which has been devised in many communities has been the establishment of a Child Abuse Registry, a central repository for the reporting of child abuse and the focal point for developing a community eco-response to the problem. The present study is a direct outgrowth of the effort to establish a Registry in Tulsa during 1969. A survey was conducted of Tulsa physicians in order to determine the need and the potential use of a registry in the community. Consequent to the survey a Child Abuse Registry was established and has been in operation for the past several years.

This report is based on a "before" and "five years after" study conducted among members of the Tulsa County Medical Association, which consisted of a sample comparative inquiry responded to by 93 doctors in the 1969 group and 71 doctors in 1974. In both groups the majority of respondents were under 50 years of age.

DATA

Table 1. Source of Information on Child Abuse During Past Year, by Percentage

	1969 $n_1=93$	1974 $n_2=71$
Newspapers	80.6	83.1
Radio	19.4	28.2
Magazine	40.9	32.4
Television	34.4	42.3
Professional Journal	Not asked	69.0
Colleagues	Not asked	35.2
Professional Organizations	44.1	35.2

Findings. The major source of information about child abuse is the newspaper. Popular media generally provide information concerning child abuse. To the extent inquiry was made, there has been majority use of professional publications and modest use of other professional sources of information concerning child abuse.

There were no significant differences between 1969 and 1974 respondents in regard to their sources of information concerning child abuse.

Table 2. Child Abuse Contacts, by Number and Percentage

	1969		1974	
	No.	%	No.	%
Treated an abused child during the past year	7	7.5	10	14.1
Ever reported that child was abused	19	20.4	18	25.4

Findings. Although the proportion of treated child abuse cases and child abuse reports had increased, the increase was not statistically significant.

Table 3. To Whom Child Abuse Was Reported, By Percentage of Separate Reports

	1969	1974
	n1=23	n2=20
Law Enforcement*	65	40
Helping*	35	60

*Law Enforcement includes police, juvenile court, sheriff, district attorney. Helping includes child welfare, Child Abuse Registry, other physicians. The categories are operational definitions only and do not connote law enforcement as non-helpful.

Findings. There was a majority shift from reporting child abuse to law enforcement services in 1969 to helping services in 1974, but the change was not statistically significant.

Marjorie Young, MSW, was graduated from the University of Oklahoma School of Social Work in 1975 and is a social worker at the Child Study Center, Children's Memorial Hospital, Oklahoma City. She is in the PhD program in Human Ecology at the University of Oklahoma Health Sciences Center. Her major interest is research in child abuse.

Table 4. Physician Attitudes Concerning Removal of Abused Children from Home Setting, by Percentage

	1969	1974
Child should be removed from care of the person who caused injury the first time accident happens.	30.1	36.6
Child should be removed from home only as last resort; parent should be given "second chance" and should be supervised and helped to improve care of child.	49.5	53.5
If it seems unlikely that the person who injured the child would do it again, it is OK to leave the child in his or her care.	15.1	12.6

Findings. A plurality (about one-half) of the respondents in both groups saw removal of the child from the home "only as a last resort." Physician attitudes between 1969 and 1974 remained stable.

Table 5. Physician Attitudes of Appropriate Action in Regard to Child Abusers, by Percentage

	1969	1974
Should be jailed or punished	26.9	16.9
Must be closely supervised and treated rather than punished	73.1	73.2
Should be left alone if injury not too severe	7.5	0

Findings. About three-fourths of the physicians in both groups preferred supervision and treatment to punishment. No statistically significant changes occurred.

Table 6. Physician Behavior in Event Present When Child Is Being Abused, by Percentage

	1969	1974
Try to stop person somehow and protect the child from being injured	83.9	84.5
Not interfere but call police	18.3	15.5
Not interfere but call child welfare	3.2	4.2
Keep out of it, having no business mixing in other people's affairs	2.2	1.4

Findings. More than four-fifths of both groups of respondents would actively intervene for the protection of the child. Response patterns for 1969 and 1974 are virtually identical.

In 1969 the respondents were asked if they would use a Child Abuse Registry if available. About three-quarters (74.2%) stated that they would. Among the 1974 respondents 15.5% had actually used the Registry. However, of the 18 physicians of the 1974 group who did report

child abuse, 60% did report to the Registry. This does show that the 1969 survey did predict Registry usage reasonably well.

SUMMARY

According to the variables measured in the 1969 and 1974 surveys the majority of physicians favored active intervention to protect a child being abused and viewed supervision and treatment of the child abuser as preferable to punishment.

There were no significant differences between physician attitudes and behavior concerning child abuse in 1969 and those in 1974. Rather, the findings are almost identical and, for the variables considered, can be viewed as showing a fixed, stable perspective. The so-called "new look" at child abuse is not statistically demonstrated in this study. □

ACKNOWLEDGEMENT

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Child Study Center, 1100 North East 13th Street, Oklahoma City, Oklahoma

SEMINAR ON PLASTIC SURGERY

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"Congenital Abnormalities of the Hand"	Edward A. Shadid, MD
"Digital Reimplantation of the Hand"	Joseph W. Hayhurst, MD
"Rehabilitation of the Hand"	Linda Schoenhals, RPT
"Reconstruction of Head and Neck Cancer Deformities"	O'Neil Engeron, MD
"Detection and Treatment of Communication Disorders Characterized by Hypernasal Speech in the Absence of a Cleft Palate"	Herbert M. Kravitz, MD
"Treatment of Eyelid Deformities Secondary to Thermal Injury"	Paul Silverstein, MD
"Positive Aspects of Cosmetic Surgery in the Clinic or Office Surgery Center"	Edward A. Shadid, MD
"Techniques to Insure a Soft Natural Breast in Augmentation Mamoplasty"	David Wiliam Foerster, MD
"Assymetry of Breasts"	Edward A. Shadid, MD

These sessions will begin at 8:30 a.m. in the hospital auditorium and will conclude at 12 noon.

For information, please contact Edward A. Shadid, MD, Program Director, 815 N.W. 12th Street, Oklahoma City 73106, 232-7592.

OSMA JOURNAL / special

The Doctor's Dilemma: MALPRACTICE

Educate, Communicate, Litigate, Legislate, Arbitrate

S. S. SANBAR, MD, PhD

The doctor's dilemma of malpractice can be alleviated through proper education, candid communication, limitation on litigation, appropriate legislation and possibly arbitration.

Law is nothing but a greenstick that bends and yields to authoritative decisions of the court and the legislature. A greenstick may be even fractured but not comminuted.

EDUCATE

In the Professional Liability Medical-Legal Guide for Physicians of the Oklahoma State Medical Association, it is stated that many malpractice suits result from failure of the physician to comprehend the legal duties the courts have decided he owes the public. Some physicians may completely neglect their medical-legal education. One of the most helpful means of avoiding litigation is a clear understanding of the legal duties of the physician and a thorough comprehension of legal doctrines with which each and every physician deals including technical assault and battery, consent, informed consent, discreet disclosure, negligence, standards of care, liabilities for acts of others, "Captain of the Ship" doctrine and the doctrine of *res ipsa loquitur* (the thing speaks for itself). All these doctrines are briefly touched upon in the Professional Liability Medical-Legal Guide for Physicians, and it is highly recommended for perusal by all physicians. The doctors must cooperate and work together in an effort to mitigate the damages and limit litigation through their vigilance and diligence, and a thorough comprehension of at least the laws of our land that concern the medical profession in general, and doctors in particular.

Efforts by our OSMA President, Arnold G. Nelson, MD, and his appropriate committees dealing with legal education to medical professionals are attempting to:

(1) Establish a required course in Professional Liability for medical students in their junior and senior years,

(2) and establish a "legal indoctrination" course for all Oklahoma State physicians which would be offered about two times a year.

COMMUNICATE

The title "Communicate or Litigate," was the subject for the "MD Day—1975" meeting of

the Oklahoma City Clinical Society, under the leadership of Doctors. James D. Funnell, Kenneth Whittington, and their fellow officers of the Society. The meeting was timely, in view of the recent plethora of literature dealing with the malpractice issue, better termed "professional liability."

One of the featured speakers at that meeting was an attorney from New Orleans, Henry Alsobrook, whose discussion on the doctors and the courts yesterday, today and tomorrow was very lucid and comprehensive. Specific points that he indicated as causes for medical malpractice included the following:

(1) Lack of communication between the physician and the patient or between the staff of the physician and the patient.

(2) Matter of education, whereby the public is more aware of lawyers and their capabilities, and secondly, the public is more aware of the high judgments awarded to plaintiffs who sue in medical malpractice cases.

(3) The so-called "loose-talk syndrome" applies to all professionals, where an innocent utterance by the professional plants the seed of malpractice in the mind of the plaintiff. Such examples include utterances by any hospital staff member, such as a nurse, an intern or a resident, about the management of the patient by the attending physician or rather the "alleged mismanagement."

(4) There seems to be a relationship between the number of malpractice suits and the more transient population as found in the United States.

(5) Finally, with the advent of no-fault auto insurance, the injured party is limited as to the amount recoverable from the insurance company, hence, the plaintiff will look towards other targets, such as doctors, to obtain higher judgments.

Professor R. Friedman, who teaches torts at Oklahoma City University School of Law, emphasizes communication, or lack thereof, as one of the most important factors leading to medical malpractice litigation.

LITIGATE

The American Medical Association published in Medical Challenge, August, 1975 a special article entitled, "Malpractice in Focus: A National Problem the States Must Solve." The report included three sections dealing respectively with the crisis in claims, the crisis in insurance coverage and cost, and some solutions to the problems.

The following are some excerpts from that article. With respect to the crisis in claims, there has been a dramatic, exponential, increase in the number of overall claims, described as "an explosion in claims." In 1970, there were a total of 26,500 claims, while in 1974 the number had increased to 41,698. It is projected that by 1980 the number of claims will be 82,300.

The states which are being hit hardest and where patients are quickest to sue include California, Florida, Maryland, New York and Wisconsin, all of which have a rate of ten to twenty-five actions per hundred MDs, with California leading by twenty-five actions per hundred MDs. The physicians most vulnerable include cardiac surgeons with an incidence of claims of 25%, vascular and orthopedic surgeons and neurosurgeons with 20% of claims in each. Following them are the plastic surgeons, gynecologists and obstetricians, general surgeons and anesthesiologists. In Oklahoma, the number of MDs being sued is comparatively small.

There has been something of a tendency on the part of insurance companies to settle medical malpractice claims. However, the generous juries have given substantial awards with the largest being over 2.5 million dollars. The number of million dollar awards is certainly on the increase. California is hardest hit by million dollar plus awards with sixteen in California history prior to 1974, eleven of which were between 1973 and 1974. Presently about one case per month on the average is a one-million dollar award in that state.

Oklahoma appears to be one of the more stable states with respect to professional medical

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A 1960 graduate of American University of Beirut, Lebanon, S. S. Sanbar, MD, PhD, limits his practice to his specialty of cardiology and internal medicine. His PhD in biochemistry, 1963, is from the University of Oklahoma. He is Clinical Assistant Professor at the University of Oklahoma Health Sciences Center. His medical affiliations include the American Heart Association, the American Diabetes Association, the American Federation for Clinical Research and the Cardiac Society, the American Society of Law and Medicine and the Law Student Division of the American Bar Association.

liability insurance, though the anticipated increase in renewal of insurance is in the order of 80%. No companies seem to be pulling out.

The premium ranges are markedly varied over the United States. The rate in Oklahoma for low-risk premium is $262, while the highest risk is $1,566. In contrast, the highest risk individual in New York pays $21,584 in liability insurance, and in California $16,000 per year. Over the $10,000 mark include Arizona and Pennsylvania at $15,000, Michigan at $12,600, Maryland at $13,000, Oregon at $12,000 and others hover around $10,000 for high-risk individuals.

It is difficult to determine what impact the east and west coasts will have on Oklahoma malpractice suits. As nationwide standards become more acceptable in medical practice, it is more likely that such standards will influence the decisions of the Oklahoma courts and hence higher judgments may conceivably be awarded. There appears to be a reluctance on the part of the Oklahoma people (1) to sue physicians and (2) to award judgments when suits are adjudicated. The physician remains highly regarded and trusted in Oklahoma. High regard, esteem and trust accorded a physician has been, must be and should always be based on conduct by the physician that is exemplary, comprising ethics, loyalty and dedication. It is hoped that the regard for the Oklahoma physician will continue and will hamper all efforts on the part of any individual or group of individuals to enhance litigation or promote large judgments.

LEGISLATE

A timely report on the subject of malpractice is in the November 1975 issue of OSMA Comment which touches upon the national background as well as the main features affecting Oklahoma physicians. In its last three paragraphs, it deals with the activities of the OSMA in regard to the endorsement of the five bills due to be considered in the next session of the Oklahoma legislature. These bills attempt to deal with the following:

(1) To define a statute of limitation in cases involving alleged malpractice,

(2) Discourage the filing of non-meritorious lawsuits,

(3) Provide that no guarantee or warranty of medical care would be valid unless stated in writing,

(4) Make information available to the jury concerning collateral sources of recovery to the plaintiff,

(5) To clarify the application of the doctrine of *res ipsa loquitur.*

The AMA is tackling the malpractice problem at a similar albeit wider scope.

(1) It is attempting to ease the immediate crisis in the availability of insurance coverage.

(2) It is seeking legislative remedies in each state to alter the present tort liability system.

(3) It is attempting to create a Medical Injury Compensation Commission which is similar to a Workman's Compensation Program to replace the existing tort liability system for handling malpractice claims.

(4) It is also attempting to establish a sliding scale for contingency fees for attorneys, eliminating the *ad damnum* clause (that part of the Lawsuit in which a specific amount of damages is requested), limiting guarantee of medical results to assurances expressly set forth in writing, eliminating injury alone as a basis for negligence in *"res ipsa loquitur,"* ruling over statements not admissible to qualify the terms of written informed consent, and permitting the provider of medical care to file a counterclaim for abuse of process before a personal injury action has been terminated.

Arbitrate

These are but two other suggested approaches to resolving the malpractice claims. There are two methods which are frequently discussed. *Private* contractual arbitration is already in existence under present state laws and is voluntary. *Compulsory* arbitration, on the other hand, is a difficult "pill" to swallow.

A Pretrial Screening Panel may aid in diminishing the number of non-meritorious lawsuits.

Role of The Federal Government

Congress is by no means dormant with respect to the malpractice problem. Federal legislation has proposed a variety of actions including: "no-fault" arbitration reinsurance, study commissions, and various modifications in the present legal systems. All these have been introduced by Congress. The main difference between state action and federal action is that the latter will impose national licensure

and relicensure standards, review of all physician services by PSRO, and acceptance of Federal Government fee schedules under Medicare.

SUMMATION

It is evident that the malpractice crisis is escalating and will continue to do so unless action is taken principally by physicians to curb such digression. Clarence Whitehead notes in his article, "The Law Proceeds to Fulfill its Historic Duty," in the Internist Reporter, October, 1975, that the medical profession has never been in such an extended state of interaction with the law and lawyers as it is now. He further notes that this condition can only escalate as most of us must know. It is hoped that doctors who are intimately familiar with health and health care delivery, will help themselves by coming to the forefront of groups pressing for legal change, in an attempt to attain a modification of the current legal structure thereby providing an optimum solution which will be beneficial to both the public at large and the physicians themselves. Whitehead notes that unless the physicians get involved in these crucial deliberations, solutions to the problems will inevitably be imposed upon them as the law proceeds to fulfill its historic duty.

Law is nothing but a greenstick that bends and yields and may be fractured but not comminuted. □

1509 North Rockwell, Oklahoma City, Oklahoma 73127. Submitted for publication November 1975.

Acknowledgment

The author thanks Professors John Amick and Ronald Friedman for their review and comments of this paper.

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News From The Oklahoma State Department of Health

Nearly 5,500 Oklahomans were poisoned last year and called the Oklahoma Poison Centers for treatment information. The largest number of these calls involved internal medicines and others were for everything from household cleaning agents, pesticides, cosmetics, to Veterinary products and venom from snakes and insects. Of these calls, 1,190 were made by physicians and other medical personnel requesting assistance.

The Oklahoma Poison Centers provided an accumulation of reference materials on the emergency treatment of over 50,000 of the most common causes of poisoning. In addition, the Poison Information Center at the State Health Department has an extensive reference library and listing of consultants where more in-depth information is required.

The Oklahoma Poison Centers stand ready to serve the medical profession and public with emergency poison information and public information programs to help reduce the number of accidental poisonings. Telephone coverage is provided at seven centers throughout the State and are listed as follows:

State Coordinating Center: Oklahoma Poison Information Center, Oklahoma State Department of Health, Oklahoma City, Oklahoma (405) 271-5454.

Associate Centers: Ada Poison Control Center, Valley View Hospital Emergency Room (405) 332-2323, Ext. 200; Ardmore Poison Control Center, Memorial Hospital of Southern Oklahoma (405) 223-5400; Lawton Poison Control Center, Comanche County Memorial Hospital (405) 355-8620; McAlester Poison Control Center, McAlester General Hospital—West (918) 426-1800, Ext. 240; Ponca City Poison Control Center, St. Joseph's Medical Center (405) 765-3321, Ext. 584; Tulsa Poison Control Center, Hillcrest Medical Center (918) 584-1351, Ext. 598. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR FEBRUARY, 1976

DISEASE	February 1976	February 1975	January 1976	Total To Date 1976	1975
Amebiasis	—	2	2	2	3
Brucellosis	—	—	—	—	1
Chickenpox	322	185	244	566	310
Encephalitis, Infectious	1	—	—	1	—
Gonorrhea (Use Form ODH-228)	1058	921	1126	2184	1919
Hepatitis, A, B, Unspecified	169	68	261	430	169
Leptospirosis	—	—	—	—	—
Malaria	—	1	—	—	1
Meningococcal Infections	7	2	4	11	4
Meningitis, Aseptic	—	1	3	3	6
Mumps	114	15	77	191	32
Rabies in Animals	6	12	6	12	24
Rheumatic Fever	—	—	1	1	1
Rocky Mountain Spotted Fever	—	—	—	—	1
Rubella	11	4	13	24	46
Rubella, Congenital Syndrome	—	—	—	—	—
Rubeola	73	9	109	182	10
Salmonellosis	13	11	9	22	33
Shigellosis	9	17	15	24	120
Syphilis, Infectious (Use Form ODH-228)	11	9	13	24	22
Tetanus	—	—	—	—	—
Tuberculosis, New Active	26	28	25	51	45
Tularemia	—	—	—	—	—
Typhoid Fever	—	—	—	—	—
Whooping Cough	—	1	1	1	1







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OKLAHOMA MEDICAL SUMMIT '76

The Spirit of '76

Oklahoma Medical Summit '76 is a combined meeting of the Oklahoma State Medical Association, the Oklahoma City Clinical Society, and the Oklahoma Academy of Family Physicians. It will be held at the Lincoln Plaza Forum in Oklahoma City on May 6th-9th, 1976, and will be designed around the Bicentennial theme,"The Spirit of '76."

This year's Oklahoma Medical Summit promises to be one of the finest ever held, featuring a varied and diversified scientific program, an interesting program of socioeconomic updates, an unusual series of Curbstone Consultations and much, much more. The meeting is credited for 20 hours of continuing medical education to the participant who attends the full four-day session.

But scientific meetings and medical education will not be the only strong points featured at Oklahoma Medical Summit '76; additionally, there will be a full program of social and sports events designed to entertain the participant. An Early Bird Cocktail Reception will kick off the meeting in traditional fashion and will provide an added incentive for early arrival. That same evening, Thursday, May 6th, the Plaza Playhouse Show will take place. This year, the vaudeville comedy group "Baggy Pants" will provide the entertainment.

Social functions will continue to be a highlight throughout the four-day session with events such as the Summit Wine and Cheese Tasting Party and Oyster Crack; the Summit Dinner and Dance, sponsored by the University of Oklahoma Medical School Alumni Association; the Presidents' Inaugural Reception and the Presidents' Inaugural Banquet and Ball.

For those who would like to devote a morning to relaxation and/or frustration, Summit will again feature a special program for the sports enthusiast. Participants can choose between golf and tennis as a means of providing sporting entertainment and a break from the traditional.

A special Ladies' Program has been set for Friday, May 7th, and will include a short coffee and registration at the Oklahoma City Golf and Country Club, a decorators' showhouse tour, followed by a luncheon and fashion show and a "Needlemania" exhibit at The Oklahoma Art Center.

Oklahoma Medical Summit '76 will be a total program for both the physician and spouse. Many hours of planning have gone into this year's meeting assuring it to be one of the finest, most informative, most entertaining ever held. □

TELEPHONE MESSAGE

While physicians are attending the Oklahoma Medical Summit in Oklahoma City, emergency calls may be referred to:

521-1223

A courtesy message center will be maintained by Southwestern Bell Telephone during Oklahoma Medical Summit in the Lincoln Plaza Forum Exhibit area.

MEETING DIGEST

HOTEL ACCOMMODATIONS

The popular Lincoln Plaza Inn will be the headquarters for Oklahoma Medical Summit '76. A large number of spacious and attractive rooms has been reserved for physicians who will be attending Summit '76.

A room-reservation card for use by Oklahoma physicians was included in a previous Summit mailing. These cards should be used whenever possible in requesting hotel reservations as all rooms at the Lincoln Plaza Inn have been reserved for Oklahoma Medical Summit '76, and this card is a hotel's means of identifying you.

If you did not receive this special card, you may contact the hotel directly by writing to the Lincoln Plaza Inn, 4445 N. Lincoln Boulevard, Oklahoma City, Oklahoma 73105. Be sure to notify the hotel you are requesting reservations to attend Oklahoma Medical Summit '76.

REGISTRATION

Summit registration will be located near the entrance to the Exhibit Hall in the Lincoln Plaza Forum. It will be located adjacent to the Summit Message Center and Summit office. The registration desk will be open from 1:00 p.m. to 5:00 p.m., Thursday, May 6th; from 8:00 a.m. to 5:00 p.m., Friday, May 7th; from 8:00 a.m. to 5:00 p.m., Saturday, May 8th; and from 8:00 a.m. to 12:00 p.m., Sunday, May 9th. Participants who preregister may pick up their function tickets and all other information at the registration desk.

OAFP ANNUAL MEMBERSHIP BUSINESS MEETING

The Oklahoma Academy of Family Physicians will conduct its annual membership meeting at 3:00 p.m. on Thursday, May 6th, at the Lincoln Plaza. The business session will be followed by the OAFP Annual Membership Sweepstakes Snacks at 5:00 p.m.

SCIENTIFIC PROGRAM

Over 20 hours of continuing medical education credit will be available to the physician who attends the entire Medical Summit '76 session. Each of the three days will feature a number of different scientific sections for the physician to choose from. Monday will feature a unique series of Curbstone Consultations and special sections on Medical Records, Alcoholism, Obstetrics/Gynecology and Surgery, Intensive Coronary Care, Pathology, ENT, and Nutrition. Featured subjects on Saturday will be Ophthalmology, Pediatrics and Internal Medicine, Breast Cancer, Urology, Anesthesiology, Internal Medicine, and Occupational Medicine. The Sunday program will include a section on Allergy and an in-depth discussion of Sports Medicine.

SOCIOECONOMIC PROGRAM

Two extremely interesting and pertinent programs have been arranged to update attending physicians on current socioeconomic topics. On Friday morning, May 7th, the Oklahoma Foundation for Peer Review will present a Summit Seminar with an update on Professional Standards Review and Utilization Review. Speakers at this session will include Kenneth Schneider, MD, Bureau of Quality Assurance, HEW Dallas Regional Office; and Hillard E. Denyer, MD, President, OFPR. Saturday afternoon, May 8th, an update on one of the central issues now facing physicians throughout the country will be held — Medical Malpractice. This Summit Seminar will take a look at the national and state malpractice problem and relate it to the physician's personal practice. Medical malpractice attorneys from the Pierce, Couch, Hendrickson, and Short lawfirm will investigate the problem from social, legal, and medical points of view.

SUMMIT LUNCHEON SPEAKERS

Two outstanding luncheon speakers, representing two different national medical organizations have been arranged for this year's Summit session. On Friday, May 7th, Herbert Huffington, MD, President-elect, American Academy of Family Physicians, will address the noon luncheon. Doctor Huffington will speak on "The Washington Scene." The

(Continued on Page 141)





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(Continued from page 139)

next day, Saturday, May 8th, a member of the American Medical Association's Board of Trustees will present the address. Joe Boyle, MD, of Los Angeles, California, will speak on "AMA Leadership on National Health Issues."

SOCIAL AND SPORTS

A full program of social and sports events has been arranged for the Summit participant. In addition to the standard Summit social activities, a special Ladies' Program has been set for Friday morning, May 7th. This program will include a short coffee at the Oklahoma City Golf and Country Club, a Decorators' Showhouse Tour, a luncheon and fashion show at the country club, and a unique "Needlemania" presentation at The Oklahoma Art Center.

A sports program sure to entertain the participant will also be held. The Annual Summit Tennis Tournament with both Ladies' and Men's Brackets will take place at The Courts, N.W. 63rd and Broadway Extension. The Annual Summit Golf Tournament will be held at Midwest City Regional Park, 711 S. Douglas Boulevard in Midwest City. For full details about Summit social and sports events see the Calendar of Events.

EXHIBITS

As always, Oklahoma Medical Summit '76 will rely heavily on technical exhibitors for financial support (see roster on page 143). The exhibit area which will also feature scientific and institutional displays will be located near the Summit meeting rooms in the Lincoln Plaza Forum.

SPECIALTY AND ALLIED GROUPS

A number of specialty and allied paramedical groups will conduct meetings in conjunction with Oklahoma Medical Summit '76. The program for each of these meetings will be printed in the official Summit program to be distributed during the registration. A great many of these programs are listed in the tentative Summit program in this *Journal*. All meetings held during Medical Summit are open to all registrants.

CURBSTONE CONSULTATIONS

The untraditional will be highlighted in Oklahoma Medical Summit '76's unique series of Curbstone Consultations. For the physician who would like to shun the traditional lecture in favor of a one-on-one discussion with experts in Otorhinolaryngology, Obstetrics and Gynecology, Orthopedics, and Neurology, the Friday morning, May 7th, Curbstone Consultations will be the answer. Approximately 80 physicians who sign up early will have the opportunity to sit down and discuss these specialties in depth. Each consultation period, which will accommodate approximately 20 physicians, will be organized in a manner which will encourage an open discussion and free dialogue. The intent of this program is to allow each participant a chance to ask any questions he may have regarding these specialties. If an informal but informative question-and-answer session appeals to you, plan now to sign up early and participate in this unique program. □

OKLAHOMA MEDICAL SUMMIT '76

Pre-Registration Deadline—
April 28, 1976

There is no registration fee for the meeting; but because of the size of this meeting, ADVANCE REGISTRATION is strongly urged.

A drawing for prizes will be made from the tickets purchased in advance of the deadline. Your tickets will be available at the registration desk upon your arrival. Grand prize will be a five-day trip for two to Montego Bay including air fare and deluxe hotel accommodations, (no cash equivalent) courtesy of Globe Trotters International. Second prize is a beautiful and unique silver Oklahoma Bicentennial Medal.

To pre-register, please use the enevelope furnished in Summit publicity mailings.



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Technical Exhibitors

The Technical Exhibits of Oklahoma Medical Summit may be seen in the Exhibit Area of the Lincoln Plaza Forum.

AAFP Group Disability Plans, Inc.
Abbott Laboratories
Academy Computing Corporation
Ayerst Laboratories
Beecham-Massengill Pharmaceutical
Blue Cross-Blue Shield of Oklahoma
Boehringer Ingelheim, Ltd.
Ralph L. Bolen Imports
Bristol Laboratories
Burroughs Wellcome & Company
CIBA Pharmaceutical Company
Cooper Laboratories
Cope Enterprises
Coyne Campbell Hospital
Credit Service, Inc.
Dictaphone Corporation
Dow Chemical Company
Eaton Laboratories
Fisons Corporation
Flint Laboratories
C. L. Frates Co.
Geigy Pharmaceutical
Gerber Products Company
Hoechst Pharmaceutical Company
International Medical Electronics, Ltd.
Ives Laboratories
Kremers-Urban Company
Lederle Laboratories
Eli Lilly & Company
Mallinckrodt Pharmaceuticals
Marion Laboratories
McNeil Laboratories
Mead Johnson Laboratories
Medco Products
Medical Opinion Research Association
Medical Plastics Laboratories, Inc.
Melton Company
***Merck Sharp & Dohme**
Merrell — National Laboratories
Mission Pharmacal Company
Natural Selections
Oklahoma Home Health
Oklahoma Medical Research Foundation
Ortho Pharmaceutical Corporation
Parke-Davis & Company
Professional Com-Data Corporation
Riker Laboratories, Inc.
Roche Laboratories
Roerig Div. Pfizer, Inc.
Wm. H. Rorer, Inc.
Ross Laboratories
Sandoz Pharmaceuticals
G. D. Searle & Company
Smith Kline & French Laboratories
Smith Kline Instrument, Inc.
Southwestern Bell Telephone Company
E. R. Squibb & Sons, Inc.
Stuart Pharmaceuticals
Summit Medical Distributors
Tri-State Pharmaceutical Company, Inc.
Upjohn Company
Wallace Laboratories
Wyeth Laboratories
United States Air Force

*Contributor to Scientific Program

PROGRAM—OKLAHOMA MEDICAL SUMMIT '76

The program for Oklahoma Medical Summit '76 will be divided into five sections: Scientific, Socioeconomic, Social, Sports, and Summit Luncheon Speakers. All events other than the sports events and a few social events will take place in Oklahoma City's Lincoln Plaza Forum.

SCIENTIFIC

Thursday Morning and Afternoon

9:00 a.m. and
1:00 p.m. Special Session: Medical Records Workshop

Friday Morning

8:30 a.m. Summit Seminar: Curbstone Consultations
Problems in Otorhinolaryngology
Professor: William B. Moran, Jr., MD, Chief and Department Head, Department of Otorhinolaryngology, OUHSC

Problems in Gynecology and Obstetrics
Professor: James Merrill, MD, Chief and Department Head, Department of Gynecology and Obstetrics, OUHSC

Problems in Orthopedics
Professor: Carlos Garcia-Moral, MD, Associate Professor of Orthopedic Surgery, OUHSC

Problems in Neurology
Professor: John W. Nelson, MD, Professor of Neurology, OUHSC

10:15 a.m. Summit Session: Alcoholism—A National Epidemic
Oklahoma District Branch of the American Psychiatric Association and Division of Alcoholism, Oklahoma Department of Mental Health
Speaker: To be announced

Friday Afternoon

1:30 p.m. Summit Seminar: Mutual Problems in Obstetrics/Gynecology and Surgery
Speakers: Abe Mickal, MD, Department of Obstetrics and Gynecology, LSU School of Medicine; John Schilling, MD, Department of Surgery, University of Washington School of Medicine

1:30 p.m. Summit Session: Intensive Coronary Care
Oklahoma Heart Association
Speakers: Charles E. Rackley, MD, Professor and Head, Division of Cardiology, University of Alabama Medical Center;

William J. Fors, MD, Chairman, Cardiopulmonary Resuscitation, Oklahoma Heart Association; Thomas F. Whayne, Jr., MD, Associate Professor of Medicine, University of Oklahoma College of Medicine; Lotfy Basta, MD, Professor and Head, Cardiovascular Section, OUHSC

1:30 p.m. **Specialty Session: Pathology**
Speaker: John H. Matsen, MD, Director, Clinical Laboratories, The University of Utah Medical Center

1:30 p.m. **Specialty Session: ENT**
Speaker: Jack Suen, MD, Professor, University of Arkansas College of Medicine

1:30 p.m. **Special Session: Nutrition**
Speakers: Elissa J. Santoro, MD, Clinical Assistant and Professor of Surgery, College of Medicine & Dentistry of New Jersey; Donald Wiggans, PhD, Professor of Biochemistry, Southwestern Medical School

Saturday Morning

8:15 a.m. **Specialty Session: Ophthalmology**
Speaker: Ron Michels, MD, Johns Hopkins University, Baltimore, Maryland

8:30 a.m. **Summit Seminar:** Mutual Problems in Pediatrics and Internal Medicine
Speakers: Robert Purcell, MD, National Institutes of Allergy and Infectious Diseases, Bethesda, Maryland; William L. Hewitt, MD, University of California Medical Center, Los Angeles

8:30 a.m. **Summit Session: Breast Cancer Updated**
Oklahoma Cancer Society
Speaker: Dan Moore, PhD, Institute for Medical Research, Camden, New Jersey

8:30 a.m. **Specialty Session: Urology**
Speaker: George W. Drach, MD, Professor and Chairman, Department of Urology, Arizona College of Medicine

9:00 a.m. **Specialty Session: Anesthesiology**
Speakers: Howard L. Zauder, MD, PhD, Professor and Chairman, Department of Anesthesiology, University of Texas Health Sciences Center, San Antonio; Douglas E. Busby, MD, Civil Aeromedical Institute, FAA, Oklahoma City

9:00 a.m. **Special Session: OUHSC Medical Students**
Speakers: Gordon Deckert, MD, Chief and Head, Department of Psychiatry, OUHSC; Joe Boyle, MD, AMA Trustee, Los Angeles; Lotfy Basta, MD, Professor, Department of Medicine, OUHSC

Saturday Afternoon

1:30 p.m. **Specialty Session: Internal Medicine**
Speakers: James C. Melby, MD, Professor and Head, Section of Endocrinology-Metabolism, Boston University School of Medicine; James L. Males, MD, Clinical Assistant and Professor of Medicine, OUHSC; David Kem, MD, Associate Professor of Medicine, Chief, Section of Endocrinology, OUHSC

1:30 p.m. **Specialty Session: Occupational Medicine**
Speaker: To be announced.

Sunday Morning

9:00 a.m. **Specialty Session: Allergy**
Speakers: Philip S. Norman, MD, Past-President, American Academy of Allergy, Baltimore, Maryland; Panel discussion participants — Philip S. Norman, MD, Leon Horowitz, MD, Tulsa; Jim Lakin, MD, Oklahoma City; William A. Cain, PhD, Microbiology-Immunology Department, OUHSC

9:30 a.m. **Summit Seminar: Sports Medicine**
Speakers: William Grana, MD, Department of Orthopedic Surgery, OUHSC; Don Cooper, MD, Medical Director, Oklahoma State University; Don Robinson, MD, Medical Director, University of Oklahoma; Jim Bell, MD, Oklahoma City; Joe B. Jarman, Jr., MD, Enid; James E. White, MD, Tulsa; Don H. O'Donoghue, MD, Oklahoma City

SOCIOECONOMIC

Friday Morning

8:30 a.m. **Summit Seminar: Updates on Professional Standards Review and Utilization Review**
Oklahoma Foundation for Peer Review
Speakers: Kenneth Schneider, MD, Bureau of Quality Assurance, HEW Dallas Regional Office; Hillard E. Denyer, MD, President, OFPR

Saturday Afternoon

1:30 p.m. **Summit Seminar: Medical Malpractice Update**
Speakers: Medical malpractice defense attorneys from the lawfirm of Pierce, Couch, Hendrickson, and Short. This firm handles medical malpractice lawsuits for The Insurance Company of North America

SOCIAL

Thursday Evening

6:00 p.m. **Early Bird Cocktail Reception**
7:00 p.m. **Plaza Playhouse Banquet and Playhouse Show**

Friday Morning

9:00 a.m. **Special Ladies' Program**

Friday Evening

5:00 p.m. **Summit Reception:** Wine and Cheese Tasting Party and Oyster Crack

7:00 p.m. **Summit Dinner and Dance**
Sponsored by the University of Oklahoma College of Medicine Alumni Association/All are invited.

Saturday Evening

6:30 p.m. **Summit Presidents' Inaugural Reception**

7:30 p.m. **Summit Presidents' Inaugural Banquet and Ball**

SPORTS

Friday

9:00 a.m. and
12:00 p.m. **Annual Summit Tennis Tournament**
The tournament will be held at The Courts, located at N.W. 63rd and Broadway Extension. The Ladies' Bracket will begin at 9:00 a.m., and the Men's Bracket will begin at 12 noon.

12:00 p.m. **Annual Summit Golf Tournament**
The Summit Golf Tournament will be held at Midwest City Regional Park located at 711 S. Douglas Boulevard in Midwest City. Tee-off time will be 12 noon.

SUMMIT LUNCHEON SPEAKERS

Friday

12:00 p.m. **"The Washington Scene"**
Speaker: Herbert Huffington, MD, President-elect, American Academy of Family Physicians, Waterville, Minnesota

Saturday

12:00 p.m. **"AMA Leadership on National Health Issues"**
Speaker: Joe Boyle, MD, Trustee, American Medical Association, Los Angeles

WET CLINICS

An informal classroom setting will identify this year's Wet Clinics featured during Oklahoma Medical Summit '76. These clinics will be scattered throughout the Summit meeting and will cover six different subjects. The Wet Clinic program follows:

FRIDAY, MAY 7th

9:00 a.m. **Principles of Advanced Life Support**
Lawrence M. Higgs, MD

10:30 a.m. **Breast Problems as Viewed by the Patient**
William E. Dalton, MD, and Jim G. Duckett, MD

1:30 p.m. **Pigmented Lesions of the Skin**
Raymond L. Cornelison, MD

3:00 p.m. **Rheumatism Review**
William K. Ishmael, MD, Richard J. Hess, MD, and John A. Blaschke, MD

SATURDAY, MAY 8th

9:00 a.m. **Principles of Advanced Life Support**
Lawrence M. Higgs, MD

10:30 a.m. **New Looks for the Aging Face**
Jim D. Duckett, MD, Joseph W. Hayhurst, MD, and Paul Silverstein, MD

1:30 p.m. **Hand Eczema**
Raymond L. Cornelison, MD

3:30 p.m. **Rheumatism Review**
William K. Ishmael, MD, Richard J. Hess, MD, and John A. Blaschke, MD □

SUMMIT LUNCHEON SPEAKERS

Two nationally recognized medical experts will present luncheon addresses during Oklahoma Medical Summit '76. Each luncheon will begin at 12:00 p.m. and will be held at the Lincoln Plaza Forum. Tickets for these luncheons will be $5 each.



Saturday, May 8th Luncheon
Speaker: Joe Boyle, MD
Trustee, American Medical Association
Los Angeles, California
Topic: "AMA Leadership
on National Health Issues"

Friday, May 7th Luncheon
Speaker: Herbert Huffington, MD
President-elect, American Academy
of Family Physicians
Waterville, Minnesota
Topic: "The Washington Scene"



ENTERTAINMENT FOR THE LADIES ATTENDING MEDICAL SUMMIT '76

Friday, May 7th, 1976

9:30-10:00 a.m. **Coffee and Registration**
Oklahoma City Golf and Country Club

10:00-11:30 a.m. **Tour of the Decorators' Show House.**
The Show House, one of the early Nichols Hills Mansions, was built in 1931 by Charles Gunter. The estate, the residence of the B. D. Eddie family for 31 years, was donated to Oklahoma City University by the Eddies. It has been loaned by the University to the Symphony for this project. The 25-room Mediterranean mansion is situated on four acres of landscaped grounds. Leading interior designers from the area will completely redecorate the interior and gardens for your inspection.

12:00 p.m. **Luncheon at the Oklahoma City Golf and Country Club.**
Fashion Show from Balliet's. (Tickets $6.00) This luncheon is for your entertainment. There will be no speakers or business conducted at this luncheon.

1:30 p.m. **The Oklahoma Art Center Association has invited us to their "Needlemania."**
This is a needlework and quilt show of many talented and famous people. They are featuring many categories: Needlepoint, Petit point, Gros Point, Bavgello, Creative Canvas Work, Quilts, Embroidery, Cross-Stitch, Applique, and Crewel. You must plan to tour the show; it will be unique, fun and spectacular!

Bus transportation will be provided from the Lincoln Plaza Forum to the Oklahoma City Golf and Country Club . . . from the Club to the Decorators' Show House . . . back to the club for luncheon and fashion show . . . to the Art Center.

Please make your reservations for the luncheon and fashion with Mrs. Ronald C. Elkins, 1802 Elmhurst, Oklahoma City, Oklahoma 73120, 848-3983.

You may purchase your ticket for the Decorators' Show House when you register at 9:30 on Friday, May 7th.

Mrs. Warren L. Felton, II, Chairman, Ladies Activities.

(Continued from Page 116)

article appeared in the February, 1976, issue of Physicians Management: **YES, FTC CAN FORCE YOU TO ADVERTISE FEES.**

> THAT'S WHAT FEDERAL TRADE COMMISSION ATTORNEYS TOLD US SHORTLY AFTER ISSUING THEIR COMPLAINT CHARGING AMA WITH ILLEGALLY RESTRICTING COMPETITION AMONG PHYSICIANS. AIM OF THE COMPLAINT NOW IS TO PUSH AMA INTO PERMITTING FEE ADVERTISING, NOT TO REQUIRE MD ADS. BUT FTC OFFICIALS CONTEND THEY DO HAVE **AUTHORITY** TO **FORCE PHYSICIANS TO BUY AD SPACE AT THEIR OWN EXPENSE.**

I believe our Washington bureaucrats have forgotten that we have a Bill of Rights as part of our United States Constitution. Too many of those chosen to lead us, are unable to do so, because they have been in Washington so long that they have become a part of the problem, rather than a part of the solution. The bureaucrats should quit tinkering with a free enterprize system that has given this nation the highest standard of living in the history of the world.

I want to thank the members of the OSMA for allowing me to serve as President during the past year. It has been a tremendously rewarding experience. During the year I have learned to appreciate what a tremendous executive staff we have in Mr. Don Blair, and Mr. David Bickham. Mr. Richard Hess is our newest executive, and he too is doing a very fine job. The secretarial staff has been extremely cooperative and helpful. I want to extend a special thanks to Louise Martin, the Editorial Assistant of the OSMA Journal. She has been a tremendous help to me. I also want to thank the membership for their united support, and request their continued united effort in the years to come.

Your new President will be Doctor Orange Welborn, of Ada, Oklahoma. He is a fine man and an excellent physician. He will be an outstanding President. Please give him the kind of support that you have given me.

I want to thank my partner in practice, Doctor George R. Randels, for his kindness and understanding during my many absences from the office during the past year.

Last, but not least, I want to thank my lovely wife, Wanda, for her kindness and understanding during my very busy year as your president.

Arnold G. Nelson, M.D.

DEATHS

E. MALCOLM STOKES, MD
1917-1976

Tulsa obstetrician, E. Malcolm Stokes, MD, 56, died February 29th, 1976. Born in Savannah, Georgia, Doctor Stokes was graduated from the Medical College of Georgia in 1942 and was later certified by the American Board of Obstetrics and Gynecology. He served with the Air Force during the Korean Conflict and was recalled later for a year's active duty as a flight surgeon in 1961. He had served an eight-year term as a member of the State Mental Health Board.

IRA C. WOLFE, MD
1895-1976

A long-time Muskogee general practitioner, Ira C. Wolfe, MD, died February 28th, 1976. A native of Narrows, Virginia, Doctor Wolfe was graduated from Baylor University College of Medicine in 1923. His medical career was spent in Muskogee except for periods of service in both World War I and World War II.

Doctor Wolfe was honored by the Oklahoma State Medical Association with the presentation of a Life Membership in 1971. □

TELEPHONE MESSAGE

While physicians are attending the Oklahoma Medical Summit in Oklahoma City, emergency calls may be referred to:

521-1223

A courtesy message center will be maintained by Southwestern Bell Telephone during Oklahoma Medical Summit in the Lincoln Plaza Forum Exhibit area.

CARDIAC ARREST AND RESUSCITATION Hugh E. Stephenson, Jr., MD Published by C. V. Mosby Company, 1974. Price $45.50 Pp. 998.

The author has made the study of cardiac arrest and resuscitation a major interest and effort since 1958, when the first edition of this book was published. From a small monograph which appeared as the first edition, the present text has been expanded to some 1000 pages which also serves as an indication of the great amount of information which has been gathered about the mechanisms of cardiac arrest.

The text incorporates major sections by the author and invited contributions by other experts. There are sections dealing with the mechanisms of cardiac arrest, the specific methods of cardio-pulmonary resuscitation in different situations and drug therapy.

This book should be available to all physicians that may be concerned with the problem of sudden, unexpected death and cardiac arrest. *Harris D. Riley, Jr., MD*

COLLAGEN-VASCULAR DISEASE. Systemic Lupus Erythematosus, Acute Dermatomyositis-Polymyositis, Progressive Systemic Sclerosis, Polyarteritis Nodosa. By John H. Talbott. Pp 285. Grune & Stratton, Inc., New York and London, 1974. $19.50.

The author of this book has had a long experience and interest in rheumatology. He is a former editor of the Journal of the American Medical Association. It is a concisely written text of 285 pages that covers four of the above disease prototypes as listed in the title. Appropriate consideration of each is given with historical background, incidence, pathogenesis, etiology, pathology and clinical manifestations as well as diagnosis and management. Perhaps the major criticism is that there is no discussion of "mixed-connective tissue diseases" and other syndromes which "overlap" these disorders.

All in all the book is a valuable addition and can be recommended for those interested in these disorders. *Harris D. Riley, Jr., MD*

DUNCAN'S DISEASES AND METABOLISM-GENETICS AND METABOLISM, Volume 1, 7th Edition, Edited by Phillip K. Bondy and Leon E. Rosenberg. Published by W. B. Saunders Company, 1974. Pp. 948. Price $26.00

This book which first appeared in 1942, enjoys wide popularity. There are some important changes in the 7th edition. Only the chapter on overnutrition remains in the comparatively brief section on Nutrition. Much of the other material dealing with this subject now appears in other chapters. Two chapters — an excellent description of the thyroid and iodine metabolism and a chapter on serotonin and the carcinoid syndrone — are new. It is unfortunate that there is no description of copper metabolism and Wilson's disease. Virtually every chapter has been revised and there are good discussions of technical advances such as radioimmunoassay and cyclic AMP.

The 7th edition continues its previous high standards. *Harris D. Riley, Jr., MD*

MANUAL OF CLINICAL MICROBIOLOGY, Second Edition. Edwin H. Lennette, Earle H. Spaulding and Joseph T. Truant. Pp. 970. American Society for Microbiology, Washington, D.C., 1974. Cloth $20.00. Flexible Cover $15.00.

The field of infectious disease and clinical microbiology is undergoing striking renewal of interest and re-evaluation of long standing procedures as well as the development of many new standardized diagnostic techniques. The American Society for Microbiology can take credit for a part of the impetus for this development. This second edition represents a significant improvement over the initial issue. The new version is about one-third longer, virtually all chapters have been re-done and much new material has been included. New chapters are grouped in appropriate sections. This is an excellent reference and certainly everyone working in microbiology and infectious diseases should have access to a copy. *Harris D. Riley, Jr., MD* □

ASSOCIATE FAMILY PHYSICIAN with internal medicine interest, rural N.E. Oklahoma near Tulsa. New clinic with family physician and physician assistant. 40-bed hospital. May lease and control practice or salary and benefits offered. 35,000 population area, recreational facilities available. Contact John D. Hesson, MD, 123 E. Fulkerson, Drumright, Oklahoma 74030 or call 918 352-2555.

WELL-TRAINED physician in Family Medicine or General Practice needed immediately for medium-sized Oklahoma city with outstanding hospital facilities and full range of specialty care. Existing practice nets $60,000 a year. Contact Key W, *The Journal,* Oklahoma State Medical Association, 601 NW Expressway, Oklahoma City, Oklahoma 73118.

LIMOUSIN HERD FOR SALE. Because of the increasing demands on our time and finances in our other business interests we have decided to sell our breeding herd of 35 Purebred, 7/8 and 3/4 Registered Limousin cattle. These good young animals were originally purchased from the finest herds in the U.S., including major show winners and have their full productive life ahead of them. They are sired by the world's top Purebred Limousin bulls. The cattle will be sold privately, in groups or individually, on a first come-first serve basis. Good opportunity to start or expand an outstanding breeding cattle herd while taking tax advantages. Mr. and Mrs. John Kusel III, Fort Cobb, Oklahoma, 1 405 643-2884.

IMMEDIATE OPENING for full-time physician to join medical division of large international petrochemical company in Midwest. Board certified in internal medicine, or would consider board qualified. Salary negotiable, plus numerous company benefits. Contact the Medical Department, Phillips Petroleum Company, Bartlesville, Oklahoma 74004.

(Continued on Page IX)

for the inflamed phase of hemorrhoidal flare-up

Anusol-HC® Cream: Rx only. Each gram contains: Hydrocortisone Acetate 5.0 mg; Bismuth Subgallate 22.5 mg; Bismuth Resorcin Compound 17.5 mg; Benzyl Benzoate 12.5 mg; Peruvian Balsam 17.5 mg; Zinc Oxide 110.0 mg. Also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil and glyceryl monostearate. Non-staining.

Anusol-HC® Suppositories: Rx only. Each contains: Hydrocortisone Acetate 10.0 mg; Bismuth Subgallate 2.25%; Bismuth Resorcin Compound 1.75%; Benzyl Benzoate 1.2%; Peruvian Balsam 1.8%; Zinc Oxide 11.0%. Also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and coloring in a bland, hydrogenated oil-cocoa butter base.

CAUTION: Federal law prohibits dispensing Anusol-HC® Cream and Anusol-HC® Suppositories without prescription.

for the maintenance and protection phase

Anusol Suppositories and Ointment: Except for hydrocortisone acetate, these forms contain the same percentages of active ingredients as listed above.

Contraindications: History of sensitivity to any component. Topical corticosteroids should not be employed in tuberculous, fungal and most viral lesions of skin (including herpes, vaccinia and varicella).

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy they should not be used unnecessarily on extended areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. When there is bacterial skin infection, topical corticosteroids should be used only with appropriate concomitant anti-microbial therapy. Prolonged or excessive use of corticosteroids might produce systemic effects.

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1976

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The JOURNAL of the Oklahoma State Medical Association

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Advertising Copy ..... July 12, 1976

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CONTRIBUTIONS

Articles accepted for publication, including manuscripts of annual meeting papers, are the sole property of *The Journal* and must not have been published elsewhere. Authority for approval of all contributions rests with the Editorial Board, and the Board reserves the right to edit any material submitted. Manuscripts should be typewritten, double spaced and submitted in original and one copy. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned on request. *The Journal of the Oklahoma State Medical Association* is not responsible for the statements or opinions of any contributor.

STYLE

Footnotes, bibliographies, and legends for illustrations should be submitted on separate sheets, double-spaced. Bibliographies should follow in order of: name of author, title or article, name of periodical with volume number, page and date of publication. These references should be alphabetized and numbered in sequence.

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NEWS

Members of the Oklahoma State Medical Association, the constituent societies of the association, and all readers in general are invited to supply news items of general interest to the profession.

ADVERTISING

All advertising copy must be approved by the Editorial Board before acceptance for publication. General and miscellaneous advertising rates will be sent on request.

EDITING SERVICE

The Editorial Board reserves the prerogative to submit contributions to a Medical Editing Service when warranted. If such is felt necessary, the Editor will contact the author for approval, informing him that there will be a modest charge for this service.

REPRINTS

Authors will receive reprint order forms from the Transcript Press, P.O. Drawer 1058, Norman, Oklahoma 73069, prior to final publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

BACK ISSUES

Microfilm copies of back issues of *The Journal* may now be purchased from University Microfilms, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

Even as this story is written, the OSMA-backed malpractice bill, SB 622, may very well be before the floor of the House of Representatives. Its final outcome is, of course, still in question, but whatever eventually develops, a number of persons deserve our thanks.

Doctors throughout the state have taken time from their busy schedules to contact their Senators and Representatives in support of this measure. In the Senate this kind of cooperation was instrumental in reversing an opinion which had caused the bill to be severely amended and weakened. The eventual 42-1 passage of SB 622 is now history, but it is an occurrence which would have never taken place without physician support.

In the House similar support enabled our malpractice measure to slide through the Insurance Committee with only one minor amendment. The vote in this committee was an unanimous "do pass." Hopefully, this same support will garner an approval on the floor of the House.

The Oklahoma Nurses Association has been quite helpful in our campaign for SB 622 as have the Oklahoma Hospital and the Oklahoma Osteopathic Associations. One person who deserves special recognition, however, is Jacques DeLier, president and general manager of television station KWTV in Oklahoma City. Mr. DeLier and KWTV have supported our bill from its initial stages and have devoted an almost unprecedented amount of editorial time in its defense. On four separate occasions KWTV has editorially endorsed SB 622, asking for Legislators and citizens of Oklahoma to do likewise.

In the latest editorial comment, aired March 24th, 1976, Mr. DeLier said:

> "Yesterday the House Insurance Committee approved and sent to the House SB 622 which sets up a progressive and improved method of dealing with medical malpractice suits in Oklahoma. Channel 9 would like to commend Chairman Gary Payne and members of his committee for his exercised wisdom in approving this long-needed legislation.
>
> "But 622 still needs the support of all Oklahomans just as all Oklahomans need the provisions of 622, which I've spoken on before.
>
> "What do you think? Are you willing to get behind this bill and support it when it comes up in the House? Let Channel 9 know."

Whatever eventually happens with this bill, KWTV has given its support and should be recognized for its efforts.

The American Medical Association has announced it will file an amicus curiae brief before the Idaho Supreme Court in a case appealing a district court decision on Idaho's professional liability insurance legislation. In the March 8th issue of the AMA Newsletter, the AMA reported that the Idaho Medical Association is seeking to overturn the district court's ruling that a provision of the law which limits malpractice recoveries is unconstitutional under that state's constitution. The AMA brief seeks to reaffirm a district court ruling that held that equal protection and due process guarantees of the United States Constitution were not violated by the Idaho legislation.

According to a recent Harris Survey the public favors physicians more than any other element of their health care. Topping the list are medical specialists who were viewed favorably by 83 per cent of the public and unfavorably by only nine per cent. General practitioners followed closely with an 81 per cent favorable rating and a 16 per cent unfavorable response. The poll average was conducted for the Federation of American Hospitals during the last part of 1975 and was presented by Harris at the group's recent annual meeting. Hospitals, by the way, came in fourth in the poll with a 70 per cent favorable rating and a 27 per cent unfavorable rating. The survey showed that while the public is generally satisfied with its health care, nearly two-thirds of those who responded are not willing to pay 10 to 15 per cent higher hospital costs, even if guaranteed better quality service and more personal attention. □

The JOURNAL of the Oklahoma State Medical Association

May 1976 Vol. 69, No. 5

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Accounting For Costs

It's pretty certain that we'll never stop hearing about the increasing costs of health care. Doctors' fees, hospital charges and drug expenses keep going up, even out-pacing the steadily rising cost-of-living figures. Of course the news media, possibly motivated by comments from the proliferating health-related bureaucracy, would lead us to believe that the principal cause of the rising costs of health care is pure greed; greedy physicians, greedy nurses, greedy hospital administrators, greedy pharmacists and greedy drug manufacturers. The campaign to villify the profession is unrelenting.

However, as is the case in every activity which is subjected to increasing regimentation, supervision, inspection, standardization and subordination, the cost of the activity itself remains relatively constant while the cost of regulating the activity soars. And in the past twenty-five years the extent to which the health-care industry has been subjected to regulation is virtually beyond the scope of comprehension, while the end is not in sight.

Imagine, if you can, how much less it would cost you to practice medicine if you didn't have to complete the hundreds of Medicare-Medicaid-insurance-social security forms you now must handle every month. And if you didn't have to be away from your office attending meetings of hospital staffs and departments which you now must attend in order to satisfy some regulation. Or to be present at some so-called educational function which although providing certain required "credits," actually provides nothing else. And if you didn't have to spend more time completing records than you spend in rendering care for your patients. And if you didn't have to practice defensive medicine or pay for malpractice insurance. Or if you didn't have to produce written justification for every one of your clearly justifiable decisions and actions.

Now, to really tax your imagination, think how much could be trimmed from the cost of hospital care if that activity could escape the garrote of senseless regulation. And apply the same exercise to the manufacture of pharmaceuticals and medical equipment and the individuals and firms which market those products.

Of course it's impossible to arrive at, or even in the neighborhood of a reasonably accurate cost-of-compliance figure for the health-care industry in this nation. It would be easier to understand the federal budget, astronomical as it is. But there are a few hard facts available which provide some clues to the significance of the entire question and suggest some solutions to the expanding problem.

The hard facts are: That health-care costs have risen in direct proportion to the degree of government regulation and intervention in health-care services. That the quality of health care has not significantly increased in terms of morbidity and mortality. That the availability of health-care has not significantly increased but has, in fact, decreased in certain areas of our nation since the government has exerted more direct influences in the field of health care. That American medicine has lost its role of leadership in the world's frontiers of health care since the government has decided to control it.

If you like our postal service, you're going to love nationalized health care. MRJ



I appreciate the confidence expressed in me by the membership of the OSMA in electing me to serve as president this year. I will do my best to perform in such a way as to earn that confidence.

This past year as president-elect, I have studied our association and its structure and many of the problems we face, so my assumption of the presidency is not unlike being chosen to be the opening of the coliseum program of the "Christians and the lions."

If we look about us at the threat to medicine and medical care as well as the threats to health care, we find ourselves surrounded by new regulations, legislation, pending investigations, etc, etc. We could thrust out in any direction and find a problem worthy of an effort by our association. Unfortunately we are a moderate sized state medical association with relatively moderate financial resources so that we must develop priorities for our efforts — in order that we may approach those problems of primary importance which have attainable goals.

During this past year, Doctor Arnold Nelson has given us excellent leadership and has done an outstanding job. Most of our councils and committees have also done a tremendous job. For these efforts every physician in Oklahoma should be grateful.

The House of Delegates accepted and passed a reorganization plan which re-structures our councils and committees and places more responsibility on council chairmen; it specifies the scope of council activity and develops a continuity of expertise in the field of the councils' activities which can be more effective in serving the needs of the physicians of Oklahoma and our patients. This reorganization brings more physicians into the decision making process and eliminates ineffective or idle committees whose special tasks and efforts are so vital to our association.

An example of what true expertise can do by the leadership of a council or committee has certainly been displayed by the activities of the Legislative Committee, under Doctor Barton Carl, in leading SB 622 to final passage by the legislature with the widespread assistance of the general membership. We are deeply indebted to Doctor Carl. Another example of this leadership was expressed by the insurance committee in the development of a comprehensive insurance program. Doctor C. Alton Brown has shown outstanding leadership as reflected by the efforts of this committee.

I mention these two councils particularly: however, most of our councils and committees have shown great expertise and leadership and are to be commended. We need broader participation by our membership, and particularly by young and new members who can learn the intricacies of council and committee work under the guidance of experienced physicians who are now serving in leadership roles.

There are many talented, thinking doctors in Oklahoma who are not using their talents to help solve the problems we face. Tapping this huge reservoir of talent during this crisis era in our professions' history will be a primary concern to me as your president.

I sincerely solicit each of you to tell me the field of our activities in which you are interested and willing to work, for we have much work to do and many problems to face, and only by unity of purpose and concentrated effort will we be able to meet our challenges for ourselves, our patients and for medicine in Oklahoma.



OSMA JOURNAL / scientific

Diagnosis of Pulmonary Embolism: A Comparison of the Lung Scan With Other Diagnostic Techniques

SCOTT K. LUCAS

How useful is the lung scan in the diagnosis of pulmonary embolism?

INTRODUCTION

Pulmonary embolism is an exceedingly common and often lethal disease. The inability of the clinician to recognize consistently the occurrence of pulmonary embolism is documented by the high incidence of pulmonary embolism at autopsy compared with the much lower incidence of antemortem diagnosis[1,2]. In one series[3], careful identification techniques revealed pulmonary embolism to have occurred in 64% of consecutive, unselected autopsies. The clinical diagnosis was made prior to death in 7.7% of those patients.

In a recent series of angiographically documented pulmonary embolism[4], hemoptysis was present in only 14% of patients, with pleuritic pain and thrombophlebitis occurring in 42% and 33% respectively. Therefore, should the physician await the occurrence of the classic triad of pleuritic pain, hemoptysis and thrombophlebitis, he will often fail to diagnose pulmonary embolism.

The complications of anti-coagulant therapy may be serious so the diagnosis of pulmonary embolus should be made with a high degree of certainty prior to instituting therapy. Indications for surgical therapy require an accurate diagnosis and knowledge of the exact location of the embolus. Among the diagnostic techniques available to the clinician is the lung scan, a technique which has assumed increasing importance in the management of patients suspected of pulmonary embolism. Its noninvasiveness and relative simplicity make it an attractive test. However, several questions must be raised: How specific is the test? How reliable is it, and how does it compare with other diagnostic procedures? (Table 1)

A search of the literature was carried out in an attempt to answer these questions. The results and critique of this search are presented. Finally, an approach to the diagnosis of pulmonary embolism is presented.

THE TECHNIQUE OF LUNG SCANNING

Perfusion Scan

The principle of perfusion lung scanning remains unchanged since its clinical introduc-

TABLE I

DIAGNOSTIC METHODS FOR PULMONARY EMBOLISM

	Specificity	Reliability	False Positives	False Negatives
Laboratory (SGOT, LDH, blood gases, etc.)	Poor	Poor	Many	Many
EKG	Poor	Poor	Many	Many
Chest x-ray	Fair	Fair	Many	Many
Perfusion scan	Good	Good	Some	Few
Ventilation/perfusion scan	Excellent	Excellent	Few	Few
Angiography	Excellent	Excellent	Few	Few

tion in 1964.[5] Following intravenous administration, radioactive macroaggregate particles ranging in size from approximately 10 to 60μ in diameter flow through the pulmonary artery branches in a distribution corresponding to the relative blood flow to each region of the lung. Since these particles are physically larger than a red blood cell (approximately 7μ in diameter), they become lodged in capillaries or precapillary arterioles in a pattern which reflects pulmonary blood flow. Relative distribution of radioactivity, however, also reflects a gravity-dependent gradient of pulmonary blood flow from apex to base as well as variations in counting sensitivity and resolution characteristics of imaging equipment.

In the case of pulmonary vascular obstruction, a reduction in radioactivity distal to the obstruction will be noted on the scan if the perfusion defect is sufficiently large to be detected by the imaging device. The physical characteristics of such devices allow identification of relatively small (< 2 cm) perfusion defects near the periphery of the lung. However, a defect of similar size located deeper within the lung parenchyma may escape detection. Similarly, a large perfusion defect located posteriorly may be masked on the anterior perfusion image, but may be easily identified on the posterior view.[6] The minimum required views include anterior, posterior and both laterals, some physicians recommend four additional oblique views.

Ventilation Scan

The ventilation scan utilizes images obtained from inhalation of ^{133} xenon (Xe) gas from a closed circuit spirometer. The distribution of ^{133} Xe through the bronchi and alveoli is recorded with a scintillation camera. Ventilation scintiphotographs are taken after a single inhalation of ^{133} Xe to total lung capacity, after rebreathing of xenon to equilibrium and during washout of xenon from the lungs.

Normally, the ventilation scan shows a rather homogeneous distribution of ^{133} xenon throughout both lungs. Disturbances in ventilation cause lung regions to be filled with ^{133} Xe slowly or not at all. Patterns of ventilation abnormalities are of diagnostic significiance[7]. These patterns will be discussed later.

CLINICAL EVALUATION

Signs and Symptoms

Clinical manifestations of pulmonary embolism can be deceptively non-specific, resulting in underdiagnosis as a major clinical problem. In a recent series[8], the most common symptom in pulmonary embolism was dyspnea (81%), followed by pleuritic pain (72%), apprehension (59%), cough (54%) and hemoptysis (34%). The most common physical signs were rales (53%) and increased intensity of the pulmonic closure sound (53%), followed by tachycardia (43%), S_3 or S_4 gallop (34%), sweating (34%) and phlebitis (33%).

Nonspecificity of symptoms is even more prominent if only patients with massive embolism are analyzed: dyspnea (79%), apprehension (61%), pleuritic pain (62%) and hemoptysis (27%). Signs of massive pulmonary embolism were tachypnea (88%) tachycardia (63%), loud pulmonary second sound (60%), rales (50%), S_3 or S_4 gallop (47%) and pleural friction rub (17%). Of 90 patients with massive embolism, 22 had only one of the last four physical signs listed above, and 13 had none. The classic triad of hemoptysis, pleuritic pain and dyspnea was noted in only 20% of patients with massive embolism. In another series of angiographically investigated pulmonary

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Scott K. Lucas is presently a fourth-year medical student at the University of Oklahoma College of Medicine. He is a member of the Alpha Omega Alpha.

embolism[4], it was concluded that no single sign or symptom was found to occur with greater frequency in patients with specific angiographic evidence for pulmonary embolism than in those with either normal angiograms or nonspecific abnormalities of the pulmonary vasculature. A similar conclusion, that there is no specific sign or symptom for pulmonary embolism, was reached by Hildner and Ormond.[9]

Laboratory Tests

Since clinical signs and symptoms are nonspecific in the diagnosis of pulmonary embolism, various laboratory tests are utilized in an attempt to increase diagnostic accuracy. Leucocytosis and sedimentation rate are nonspecific. The diagnostic triad of elevated LDH, normal SGOT and elevated bilirubin is present in 4% of patients with documented pulmonary embolus and of no value in diagnosis.[8,10]

Analysis of arterial blood gases may be useful in the diagnosis of pulmonary embolism. Patients usually present with hypoxemia and hypocapnia. Hypoxemia is caused by ventilation/perfusion abnormalities and hypocapnia by hyperventilation. However, hypoxemia and hypocapnia are common in many cardiopulmonary diseases other than embolism. Also, many patients with pulmonary embolism do not develop significant hypoxemia or hypocapnia so that normal $P_a O_2$ and $P_a CO_2$ values do not exclude the diagnosis.[10]

Decreased systemic arterial oxygen tension ($pO_2 < 80$ mm Hg) has been suggested as a valuable screening test for acute pulmonary embolism.[11] However, measured values of pO_2 greater than 80 mm Hg were obtained in 12% of patients with angiographically documented pulmonary embolism not receiving oxygen.[8]

Electrocardiogram

The value of the electrocardiogram was evaluated in a recent series.[12] In massive embolism, the electrocardiogram was normal in 6% of patients. With submassive embolism, 23% of patients had a normal electrocardiogram. Since one or more of the traditional manifestations of acute cor pulmonale ($S_1 Q_3 T_3$, right bundle branch block, P pulmonale or right axis deviation) occurred in only 26% of patients, one could not rely primarily upon these electrocardiographic abnormalities for the diagnosis of pulmonary embolism. The most common ECG abnormalities were non-specific T wave changes which occurred in 42% of the patients.

CHEST RADIOGRAPH

Chest radiographs can be of diagnostic value, although a normal chest film is frequent in pulmonary embolism. A frequent abnormality is elevation of the diaphragm, seen in 41-62% of angiographically documented cases of pulmonary embolism.[8,13] This change probably reflects the pneumoconstriction associated with embolism. Also frequently seen is focal oligemia distal to an embolus (Westermark's sign). Although said to be present in 70% of proven emboli,[13] the existence of an avascular zone is subject to much interpretative disagreement. Also noted with varying frequency are infarction, atelectasis, proximal arterial dilation and pleural effusion.[8] Such findings are not commonly seen and should not be regarded as diagnostic.

The radiograph and lung scan together provide additional and valuable information. This will be discussed later.

PULMONARY ANGIOGRAPHY

Pulmonary angiography can provide specific information about the anatomy of the pulmonary vasculature as well as the morphology and extent of lesions within the pulmonary vessels. Perfusion scanning, on the other hand, provides only information regarding arteriolar-capillary blood flow through certain regions of the lung. Thus angiography is the more definitive procedure for absolute diagnosis of pulmonary embolism. However, angiography is an invasive procedure with a higher degree of morbidity and a mortality of 0.3%.[14] In addition, angiography has diagnostic limitations requiring care in interpretation.

The only two reliable angiographic findings associated with pulmonary embolus are filling defects and "cut-off" of vessels.[14,15] A filling defect is the negative image made by the embolus in the radiopaque contrast material. The cut-off is the abrupt cessation of contrast material at the site of total embolic occlusion. Filling defects are more common than cutoffs because most emboli are not totally occlusive and allow a certain amount of radiopaque substance to flow past the site of the lesion.[10]

Other abnormalities suggestive of pulmonary embolism include zones of decreased or absent flow, abnormal tapering of a vessel, de-

layed opacification of arteries and failure to visualize smaller pulmonary artery branches, the "pruning effect." These findings are nonspecific for pulmonary embolism. For example, failure to visualize pulmonary arterial vessel patterns in certain lung areas may mean embolism although other disease processes may produce a similar appearance by constriction or destruction of vessels. Also, standard angiography does not provide adequate visualization of the smaller pulmonary arteries, especially below segmental level.[10]

COMPARISON OF ANGIOGRAPHY WITH LUNG SCANNING

Arteriography has been shown to provide anatomic localization of pulmonary embolism. The question now remains: To what extent does the lung scan correlate with arteriography?

The diagnostic reliability and specificity of perfusion scanning has been investigated by several groups by comparing scan results to pulmonary angiography. In one series by Poulose, *et al*[4], 64 patients with clinical diagnosis of pulmonary embolism were investigated with perfusion scanning and arteriography. In 24 patients with lung scans highly suggestive of pulmonary embolism, (*ie,* perfusion defects corresponding to specific anatomical segments of the lung in combination with a normal chest film or film suggestive of pulmonary embolism) specific angiographic evidence of pulmonary embolus was found in 18 (75%). Diffuse, patchy and non-segmental perfusion defects were seen in 28 patients, seven of whom had angiographic abnormalities specific for embolism. In 12 patients with a normal lung scan, none showed angiographic evidence for pulmonary embolism.

To define further the value of the perfusion scan in the diagnosis of pulmonary embolism, one must consider the occurrence of false negative and false positive results. In the Urokinase Pulmonary Embolism Trial Series of 296 patients investigated with both scan and arteriography, there was no instance in which the scan was completely normal in the presence of an abnormal arteriogram.[8] A low incidence of false negative results have been noted by others.[16–18] However, experimental studies with autopsy control have indicated that falsely negative diagnoses may occur, largely related to interpretative errors.[15] It is noteworthy that errors of omission were more common with large rather than with small pulmonary emboli. Larger emboli such as those in the main pulmonary arteries, less commonly produce complete vessel obstruction. It has been demonstrated that substantial narrowing of a lobar vessel can be induced without causing marked alteration in total lobar blood flow.[19] Since the perfusion lung scan demonstrates abnormalities in arteriolar-capillary flow, not in the degree of vascular patency, it is possible that a significant reduction in luminal area by a partially accluding thrombus may result in a mild decrease in flow that cannot be appreciated by current technique. Also, a major embolus may exist in either the main pulmonary artery or in both major branches so that the flow decrease is equal bilaterally, resulting in a normal perfusion scan.

False negatives may also result from loss of flow in relatively small zones of lung perfusion, below the resolution ability of the technique. Resolution is limited to flow defects greater than two cm from the lung surface. Thus, even with multiple views and careful technique, false negative diagnoses may occur.

False positive diagnoses really do not occur with perfusion scanning, *ie,* if a scan defect is present, there is a decrease in arteriolar-capillary blood flow.[15] However, processes other than embolism may alter pulmonary blood flow. Such processes include those of pulmonary origin such as pneumonia, neoplasm, chronic obstructive pulmonary disease and sarcoid, as well as those of cardiac origin such as congestive heart failure and mitral stenosis.[18-20] Methods of distinguishing these from pulmonary embolism will be discussed below.

False positive and false negative diagnoses are also associated with angiography. The incidence of angiographic false positives is a function of both the type of angiographic defect which is accepted as evidence of pulmonary embolism and the type of patient evaluated, especially with respect to the presence of cardiopulmonary disease.[14,15] False negatives occur as a function of angiographic technique and interpretation. Especially noteworthy is the inability of standard angiography to detect small peripheral emboli.

The data of comparison studies support the general expectation that the lung scan is more

sensitive and angiography more specific.[15, 21] In addition, both techniques are associated with false negative and false positive results, especially with emboli at both extremes of size. In clinical use, however, the incidence of false negative scans is low.[22] Since both techniques have diagnostic limitations, maximum information may be obtained by considering scanning and angiography as complementary rather than competitive techniques.[18] Both techniques together may provide more information than either technique alone. Clinical situations will therefore indicate the diagnostic technique to be utilized in the management of each individual patient.

Defects observed in perfusion lung scans have been shown to reflect accurately regional distribution of pulmonary blood flow. However, no direct information is gained concerning the cause for a disturbance in regional flow distribution. Cardiopulmonary diseases other than pulmonary embolism can alter regional blood flow and thereby produce perfusion scan defects. Because the perfusion scan cannot distinguish defects due to primary vascular disease from those due to pulmonary parenchymal disease, much confusion is associated with the interpretation of perfusion scans.

COMBINED VENTILATION AND PERFUSION SCANS

To increase diagnostic accuracy, xenon — 133 ventilation scans may be used in conjunction with perfusion scanning. The experience of several investigators indicates the combined use of ventilation/perfusion scans permits diagnostic conclusions not possible on the basis of perfusion studies alone.[19, 20, 23] Two major patterns of diagnostic significance have been identified: (1) absent or reduced blood flow to a lung zone with preservation of homogeneous ventilation and (2) marked reduction or absence of both blood flow and ventilation. The first pattern is associated with the presence of congenital or acquired pulmonary vascular obstruction. The most common cause of this ventilation/perfusion pattern is pulmonary embolism but pulmonary vasculitis, pulmonary artery, agenesis and pulmonary artery branch stenosis should also be considered. The second pattern implies primary parenchymal diseases including emphysema, bullous lesions, infiltrative-consolidative processes and endobronchial obstruction.

However, a simple classification of vascular vs parenchymal disease does not identify all ventilation/perfusion (V/Q) abnormalities encountered clinically. For example, pulmonary embolism and other vascular disease may partially obstruct blood flow resulting in high V/Q rather than the infinite V/Q encountered with total obstruction. Also to be considered are intrapulmonary shunts which appear as zones in which ventilation is absent or diminished but perfusion continues (low V/Q). Such patients with shunt abnormalities have no perfusion defect, but have ventilation defects in zones which remain perfused. Limitation in diagnostic accuracy also occurs in pulmonary embolism as the lung undergoes pneumoconstriction secondary to alveolar hypocapnia. The resulting decrease in ventilation is associated with an abnormal ventilation scan. This phenomenon may be reduced by oxygen inhalation and hyperventilation prior to ventilation scanning.[7]

Another factor which may alter the V/Q pattern of pulmonary embolism is the development of infarction or congestive atelectasis in the embolized zone. Should this occur, the scan pattern will become indistinguishable from that of parenchymal disease, that is, lack both ventilation and perfusion. However, knowledge of the pathophysiology of pulmonary embolism minimizes the difficulty in scan interpretation. Infarction is an uncommon consequence of embolus; occurring in 10% of pulmonary emboli.[25] Congestive atelectasis occurs more commonly, but requires 48-72 hours to become manifest. Ventilation and perfusion scans prior to this time period should be unaffected. Also, the development of atelectasis or infarction is usually associated with radiographically visible infiltrates. Therefore, unless an infiltrate is visible on chest film, the characteristic scan pattern of pulmonary embolism should remain unchanged.[7] Also, because most emboli are multiple, diagnostic ventilation/perfusion patterns may be observed in portions of the lung not affected by infarction or congestive atelectasis.

In addition, situations exist in which absent or decreased regional blood flow is based on vasoconstrictive rather than anatomical absence or obstruction (*eg* mitral stenosis).[23] Clinical information and infusion of pulmonary vasodilators may be utilized to differentiate these lesions.

A technical problem inherent in the use of

radioisotopes occurs with the use of both ventilation and perfusion scans. The selection of patients for ventilation scan would ideally be based on the results of the perfusion scan and would be performed immediately afterwards. The resulting benefits would include more rapid diagnosis, fewer unnecessary procedures and better positioning for optimum views of the suspected lesion.

Technical problems associated with the time sequence of ventilation/perfusion scanning have been investigated and it has been shown that single-breath ventilation studies can be performed immediately after perfusion scanning with a negligible loss of diagnostic information.[24] Although significant interference occurs with equilibrium and washout studies, the diagnosis of pulmonary embolism requires only the demonstration of abnormal ventilation, information which can be obtained from the single breath study alone.

CONCLUSION AND DIAGNOSTIC APPROACH

The diagnosis of pulmonary embolism begins with clinical assessment, electrocardiogram and chest film. The combination of a negative chest film, or film suggestive of pulmonary embolism, and a perfusion scan with multiple, segmental perfusion defects is sufficiently diagnostic to begin therapy unless anticoagulants are contraindicated. If the scan is negative, the probability of pulmonary embolism is low.

If the chest x-ray is abnormal but nonspecific for pulmonary embolism, and the diagnosis remains unclear after perfusion scan, a ventilation scan is indicated. This situation often occurs in a patient with obstructive lung disease who develops an episode of tachypnea and dyspnea. The perfusion scan alone is inadequate since the pre-existing lung disease may produce perfusion defects. If the V/Q study indicates absent perfusion and continuous ventilation in the absence of known vasculitis or congenital vascular abnormalities, therapy should be instituted.

Pulmonary angiography is reserved for those patients in whom diagnostic accuracy is essential and in whom the clinical data, chest film and V/Q studies are inconclusive. Such patients include those in whom anticoagulant therapy is particularly dangerous or contraindicated and those in whom surgery is considered. Specific examples include suspected pulmonary embolus in patients with a history of gastrointestinal or intracerebral hemorrhage or those for whom embolectomy or caval interruption is considered.

A perfusion lung scan is also indicated in patients with pre-existing lung disease who are at high risk for pulmonary embolus. Should embolism be clinically suspected at a later date, a comparison lung scan is available.

Serial lung scans may also be of benefit in following the resolution of pulmonary embolism and detecting recurrence.

In general, the requirement for diagnostic precision increases with the potential mortality and morbidity of therapy. The necessity of diagnostic accuracy dictates the need for the more extensive, costly and invasive procedures.

The perfusion lung scan, in combination with chest film and ECG, is sufficient for the diagnosis of pulmonary embolism in most clinicial situations. With pre-existing pulmonary disease, combined ventilation/perfusion study is often necessary. When anticoagulant therapy is particularly dangerous or surgery is considered, pulmonary angiography is required.

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REFERENCES

1. Towbin, A. Pulmonary embolism: incidence and significance. *J. Amer. Med. Assoc.* **56:**209, 1954.

2. Morrell, M. T. and Dunnill, M. S. The post mortem incidence of pulmonary embolism in a hospital population. *Brit. J. Surg.* **55:**347, 1968.

3. Freiman, D. G., Suyemeto, J., and Wessler, S. Frequency of pulmonary thromboembolism in man. *N. Engl. J. Med.* **272:**1278, 1965.

4. Poulose, K. P., Reba, R. C., Gilday, D. L., et al. Diagnosis of pulmonary embolism. A correlative study of the clinical, scan, and angiographic findings. *Brit. Med. J.* **3:**67, 1970.

5. Wagner, H. N., Jr., Sabiston,D. C., Jr., McAfee, J. G., et al. Diagnosis of massive pulmonary embolism in man by radioisotope study. *N. Eng. J. Med.* **271:**377, 1964.

6. Ashburn, W. L. and Moser, K. M. Pulmonary ventilation and perfusion scanning in pulmonary thromboembolism in *Pulmonary Thromboembolism,* Moser, K. M. and Stein, M. (Eds.). Chicago: Year Book, 1973.

7. Moser, K. M., Guisan, M. Cuomo, A. J. and Ashburn, W. L. Differentiation of pulmonary vascular from parenchymal diseases by ventilation/perfusion scintiphotography. *Ann. Int. Med.* **75:**597, 1971.

8. The Urokinase Pulmonary Embolism Trial, A national cooperative study. *Circulation (Supplement II).* **47:**86, 1973.

9. Hildner, F. J. and Ormond, R. S. Accuracy of the clinical diagnosis of pulmonary embolism. *J. Amer. Med. Assoc.* **202:**567, 1967.

10. Moser, K. M. Diagnostic measures in pulmonary embolism. *Basics of RD.* 3:3, 1975.

11. Szucs, M. et. al. Diagnostic sensitivity of laboratory findings in acute pulmonary embolism. *Ann. Int. Med.* **74:**161, 1971.

12. Stein, P. D., et al. The electrocardiogram in acute pulmonary embolism. *Prog. Cardio. Dis.* **17:**247-257, 1975.

13. Simon, M. Plain film and angiographic aspects of pulmonary embolism

in *Pulmonary Thromboembolism*. Moser, K. M. and Stein, M. (Eds.). Chicago: Year Book, 1973.
14. Stein, P. D., et al. Angiographic diagnosis of acute pulmonary embolism: Evaluation of criteria. *Amer. Heart J.* **73:**730, 1967.
15. Moser, K. M., Hansanyi, P., Rios-Garriga, G., et al. Assessment of pulmonary photoscanning and angiography in experimental pulmonary embolism. *Circulation* **39:**663, 1969.
16. Poulose, K. P., Reba, R. C., Wagner, H. N. Jr. Characterization of the shape and location of perfusion defects in certain pulmonary diseases. *N. Engl. J. Med.* **279:**1020, 1968.
17. S. Reich, personal communication.
18. Freeman, L. M., Zelefsky, C. K., Kaplar, N., et al. Diagnosis of pulmonary embolism with scanning and angiographic techniques: a correlative study. *J. Nucl. Med.* **9:**394-401, 1968.
19. Moser, K. M. and Miale, A., Jr. Interpretative pitfalls in pulmonary photoscanning. *Am. J. Med.* **44:**366-376, 1968.
20. Quinn, J. C. and Head, C. R. Radioisotopic photoscanning in pulmonary diseases. *J. Nucl. Med.* **7:**1-22, 1966.
21. Tow, D. E. and Simon, A. L. Comparison of lung scanning and pulmonary angiography in the detection and follow-up of pulmonary embolism. The Urokinase Pulmonary Embolism Trial Experience. *Prog. Cardiovascular Dis.* **17:**239-245, 1975.
22. Wagner, H. N., Jr. and Strauss, W. H. Radioactive tracers in the differential diagnosis of pulmonary embolism. *Prog. Cardio Dis.* **17:**271-82, 1975.
23. Freidman, W. F., Braunwald, E. Alterations in regional pulmonary blood flow in mitral valve disease by radioisotope scanning. *Circulation*, **34:**367, 1966.
24. Jacobson, J. G. ^{133} Xe ventilation scanning immediately following the 99mTc perfusion scan. *J. Nucl. Med.* **15:**964, 1974.
25. Smith, G. T., Dexter, L. and Dammin, G. J. Postmortem quantitative studies in pulmonary embolism. In Sashara, A. A. and Stein, M., eds. *Pulmonary Embolic Disease*. New York. Grune and Stratton, 1965.

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A CONFERENCE ON DEPRESSION:

The Relationship of Brain and Behavior

June 13th, 1976

Lincoln Plaza Inn **Oklahoma City, Oklahoma**

Sponsored by the Department of Psychiatry and Behavioral Sciences, University of Oklahoma Health Sciences Center.

8:00-8:15 REGISTRATION

MORNING SESSION: MOLECULAR APPROACHES

8:15-8:30 Introduction by Chairperson: Harold Williams, Ph.D., Distinguished Professor, Department of Psychiatry and Behavioral Sciences, University of Oklahoma

8:30-9:15 An Evolving Psychobiological Model for The Depressions: Hagop Akiskal, M.D., Assistant Professor, Department of Psychiatry, University of Tennessee, Memphis

9:15-10:00 Limbic System-Pituitary-Adrenal Disturbance in Depression: Bernard Carroll, M.D., Professor, Department of Psychiatry, University of Michigan, Ann Arbor

10:00-10:15 COFFEE BREAK

10:15-11:00 Estrogens—Implications for Psychology and Physiology in Depressions: Donald Broverman, Ph.D., Director, Psychology Department, Worcester State Hospital, Massachusetts

11:00-11:45 Implication of Neurotransmitter Systems Malfunctions for the Psychology of Depression: Larry Stein, Ph.D., Wyeth Laboratories, Professor, Dept. of Psychology, University of Pennsylvania

11:45-12:30 Question and Answer Session

12:30-1:30 LUNCHEON

AFTERNOON SESSION: ORGANISMIC APPROACHES

1:30-1:45 Introduction by Chairperson: John Rush, M.D., Assistant Professor, Department of Psychiatry and Behavioral Sciences, University of Oklahoma, Oklahoma City

1:45-2:30 Psychophysiological Studies in Depression: M. Buchsbaum, M.D., National Institute of Mental Health, Bethesda

2:30-3:15 Physiology and Behavior in Separated Monkey Infants—Recent Findings and Theoretical Considerations: Martin Reite, M.D., Associate Professor, Department of Psychiatry, University of Colorado, Denver

3:15-3:30 COFFEE BREAK

3:30-4:15 The Implication of Animal Models of Depression for Effective Interventions: Stephen Suomi, Ph.D., Associate Professor, Department of Psychology, University of Wisconsin, Madison

4:15-5:00 Question and Answer Session

5:30-7:00 COCKTAILS (Cash Bar)

7:00-8:30 DINNER

8:30-9:15 Depression—A Psychobiological Response: SPECIAL GUEST LECTURER—Gerald Klerman, M.D., Professor, Department of Psychiatry, Harvard Medical School, Boston

A registration fee of $45.00 may be mailed to the Department of Psychiatry and Behavioral Sciences, University of Oklahoma Health Sciences Center, P.O. Box 26901, Oklahoma City 73190 or to William Orr, PhD, Veterans Administration Hospital, 921 N.E. 13th St., Oklahoma City 73104.

An Approach To The Prophylaxis Of Child Abuse And Neglect

DONALD R. PFEIFER, MD
CATHERINE AYOUB, RN, MSN

A community hospital SCAN Team detected an epidemic of child abuse. A comprehensive preventative program was developed to keep children from being sent home to die.

Hillcrest Medical Center is a non-governmental community hospital in Tulsa, Oklahoma. The Pediatric Department consists of a 39-bed unit and 50 newborn cribs. In the year 1974, Hillcrest recorded 119 cases of abuse and neglect. Forty percent of these cases were abuse, 30 percent neglect and 30 percent were failure to thrive. In the first six months of 1975, Hillcrest has already recorded 74 cases of Abuse and Neglect.

Of the 47 cases of Abuse in 1974, 36 percent (17) cases were burns. Hillcrest is the burn center for Northeast Oklahoma and it receives a large number of burn referrals. The large number of burns due to Abuse was surprising. The largest number of burns from Abuse is caused by hot water and this fact has led us to look with suspicion at all burns resulting from scalds. One-fourth (12) of the cases of Abuse were fractures; 15 percent (7) of the cases were head injuries and 15 percent (7) were extensive bruises and abrasions.

There were four other injuries of other sorts, including sexual Abuse. Seventy-five percent of the cases of Abuse occurred in children under 24 months of age. There were three deaths. All dead on arrival at the hospital.

Of the children suffering from neglect there were about equal numbers of medical neglect, pneumonia, severe anemia and severe malnutrition and these four categories comprised one-half of the cases of Neglect. Thirty-eight percent of the Neglect occurred in the first 12 months of life with about equal distribution of neglect throughout the rest of childhood years to age 16.

Thirty-two cases of failure to thrive occurred in the first 18 months of life with 53 percent occurring in the first six months of life.

Fifty-seven percent of our cases were reported to the Children's Protective Unit. In every instance our reports were found to be valid. Our statistical findings suggested the Abuse problem was of epidemic proportions. Therefore, a coordinated plan was developed between the emergency department, Burn Unit, Pediatric and Newborn Units, and the outpatient clinic.

First, a SCAN (Suspected Child Abuse and Neglect) team was developed and the proposal was presented to the Board of Trustees for ap-

proval. The team consists of pediatricians, social workers, and pediatric mental health nurses. It has the authority to cross departmental lines and investigate all cases of suspected Abuse or Neglect. Many SCAN consults are initiated by observant and concerned nurses. The SCAN team may order laboratory tests and X-rays to help confirm the diagnosis of abuse. If it appears that abuse or serious neglect has occurred the SCAN team reports the case by phone to the Children's Protective Unit, following up with a written report on a form designed by the SCAN team. Oklahoma law requires that a written report be filed following a verbal report. Frequently more information is on the medical chart than is necessary. For this reason a form was developed to present medical information in "Lay" terms and any appropriate comments or interpretations may be made by the SCAN team member filling out the report.

While the SCAN team was gaining experience in the investigation of cases of Abuse, nurses in the newborn nursery were observing mothering patterns. Aberrant mothering patterns suggested that many of the babies would return later to the pediatric unit suffering with Neglect or Abuse. Concerned nurses often expressed the feeling that they were sending these babies home to die. We found that there was no legal way for the Children's Protective Unit to intervene in an effort to prevent Abuse or Neglect.

An innovative preventive program had to be developed. Thus, the baby "At Risk" was assessed by the following criteria:

1. Low birth weight infant.
2. Infant with a feeding problem.
3. Infant with congenital defects or other complicating medical problems.
4. Mother or baby with a positive test for syphilis or gonorrhea.
5. Questionable or poor situation in the home.
6. Suspected abuse of drugs.
7. Past history of children with poor growth.
8. Past history of unusual sibling death.
9. Past history of abused or neglected children.
10. Combination of above.

When a case is found to meet these criteria, a coordinated investigation is begun as follows:

The mother is interviewed by a hospital social worker who is specially concerned with Abuse. A written report is placed on the hospital chart and a copy of the report is filed in the outpatient chart.

Public health nurse referral is made by the nurse who is the Hospital's Public Health Coordinator. A written report from the public health nurse visiting in the home is filed in the inpatient and outpatient charts.

A pediatric mental health nurse consultation is obtained if deemed appropriate and her written report is also filed.

The nurse in the newborn unit fills out a written report form for the outpatient record, assessing the attitudes of the parents, their interest and cooperation, and outlining special problems that the infant might have.

The nurse in charge of the outpatient clinic is a trained pediatric nurse practitioner. She does a physical assessment of the baby in the nursery and offers the mother her services. This gives the mother a familiar contact in the outpatient clinic in addition to the social worker who also is in the OPD during the "At Risk" clinic.

Similarly on the pediatric unit all service cases are assessed by the social worker, pediatric mental health nurse and the public health coordinator. Their reports are filed with the inpatient and outpatient records along with the assessment by the nurse in the pediatric unit who is caring for the child. In addition, a copy of the admission history and physical examination and the discharge summary is placed in the outpatient chart.

All interviews are conducted by trained personnel. Every effort is made to investigate a suspected Abuse or Neglect case in a non-accusatory fashion. Interested and concerned hospital workers offer a "Helping Hand" to a family in turmoil. Since families are in the hospital requesting help, accusations achieve nothing and cause the family to be defensive. The exact details of Abuse are not usually necessary and should not be sought aggressively. Frequently, we find that the family sees us as non-threatening and will voluntarily reveal the circumstance behind the Abuse.

As can be seen, a great deal of information is filed in the chart so the physician seeing the child in the "At Risk" clinic can make an appropriate assessment and disposition of the patient.

The chart of each "At Risk" patient is easily identifiable by an inconspicuous green triangle stamped on it. At the conclusion of each clinic, each chart is reviewed by the team of pediatri-

cians, the pediatric mental health nurse, social worker, pediatric nurse practitioner, outpatient receptionist, the pediatric resident in the ambulatory pediatric service and the medical students present in the clinic.

A report is sent to the Neglect Unit or the Juvenile Court, citing either favorable or unfavorable progress, if the patient is under the supervision of these services. In cooperation with the Children's Protective Unit a recent addition to our clinic has been the presence of trained, Lay Volunteers of the neglect unit. The director of these volunteers attends the "At Risk" review of charts at the conclusion of each clinic and coordinates the use of volunteers in our particularly difficult cases.A concerted effort is made to see the patients promptly who are brought in by these volunteers.

Referrals are made to social or medical organizations as deemed appropriate such as Public Health, Children's Medical Center, Tulsa Psychiatric Foundation, Family and Children's Services, Homemaker Services, Neighborhood Counseling Services, The Children's Protective Unit, The Juvenile Court and a host of other social and welfare organizations operating in Tulsa County.

If a patient labeled "At Risk" does not keep an appointment the clinic social service makes an effort to contact the family to find out why the patient did not return and to arrange reappointments. If there is persistent refusal of the family to return to the clinic and there is a distinct concern about the welfare of the patient, a written report is sent to the Neglect Unit or the Juvenile Court for disposition.

Usually, abuse of a child occurs during a family crisis. An important clinic person in a crisis situation is the outpatient receptionist. She must be able to identify the "At Risk" family and promptly appoint the family to the clinic for crisis intervention. The pediatric nurse practitioner is in the outpatient clinic at all times. She may do a physical assessment and is a familiar person with whom the family has already had contact. Appropriate social agencies referrals are made trying to abort the crisis and keep it in remission.

RESULTS: Since the operation of the "At Risk" clinic in the last nine months no patient has had to be hospitalized for Abuse or neglect except for initial evaluation of a new patient or the investigation of medical illness.

Occasionally in severely disturbed families temporary foster home placement is necessary. Usually these children can be returned to the family within a year with continued help and supervision offered in the "At Risk" clinic. Only in those families where the parents are psychotic or seriously disturbed is it necessary to terminate parental rights, and place the child for adoption.

We are now receiving frequent requests from the Children's Protective Unit, public health agencies and the juvenile court to work with them and their cases in a coordinated fashion.

PEDIATRIC "AT RISK" PROGRAM

The Pediatric At Risk Program evolved out of an awareness that a significant number of infants and children, who were either born at this hospital or who were admitted to the pediatric service for common medical problems, were to be seen later as children abused and neglected. Although significant efforts to identify and treat abused children had been established within the hospital, it appeared that we were waiting until after the fact to intervene with these particular children and families. Consequently, the task of providing pediatric care for the at-risk-child and family was undertaken. A family-centered care model which emphasizes the family as a unit and sees as priority the coordination and continuity of care was used in the conceptualization and in-

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itiation of this program. The overall goals of At Risk are to help expand the child's and family's potential for health, and to attempt to prevent poor health, neglect, and abuse. Three different segments of the program have been identified a follows:

1. Inpatient screening of infants and children.
2. Inpatient protocol and teaching programs in child and family health.
3. Pediatric At Risk Out-Patient Clinic.

Since the program's official beginning in January 1975, approximately 270 patients have been seen in the At Risk Program. Of these 270 cases, 240 have received outpatient care through the Pediatric At Risk Clinic. The 30 children who never reached the clinic were either placed in foster homes on discharge from the hospital or lived too far away to be able to reach the clinic on a regular basis. Children and the families move throughout these three segments of the program according to their needs.

At any given time there has been an average of between 110 and 150 active cases in the program. The At Risk Clinic is held weekly and anywhere from 20 to 35 patients are seen in any given week. Inpatient contacts average approximately 10 to 15 a week. A great number of contacts, either through phone calls, visits to the emergency room, or individually scheduled appointments take place with clinic families throughout the week. Families who have need for a "Life Line," have the ability to contact certain clinic members at any time.

Five primary objectives have been developed to achieve goals of the At Risk Program. They are as follows:

1. Coordinated and continuous medical care.
2. Increased knowledge of positive health maintenance and sense of personal worth of the family.
3. Identification of areas of family stress.
4. Facilitation of referral.
5. Identification of safety limits of parent-child relationships.

1. The first objective is to provide coordinated and continuous medical care for children and secondarily for their families. This does not necessarily mean that the total care for these children is provided by the At Risk Clinic, but that specialty clinics and other agencies within the community are used to their potential in an effort to aid the family. Written and verbal communications with other clinics and agencies are a part of the program. The review sessions following each clinic aid individual team members in taking responsibility for follow-up.

2. The second objective of the program is to increase feelings of personal worth of parent and child, and to provide them with increased knowledge of health maintenance techniques. First of all, the continuity and coordination described above helps structure these families in dealing with their problems and obtaining needed care. A number of parents need help to pull together the loose collection of their unintegrated, disparate concepts of self. Structured feeding schedules, care schedules, "cuddling and holding" schedules help to organize chaotic lives. Specific indications for calling the physician or the nurse are also given to parents. The stress of "Come back PRN," or even "call me when Bobby has a fever" is just too loose. Follow-up appointment dates are always given, and parents are given specific instructions such as, "If the child's temperature is over 101 rectally, call me at this number."

What kind of families need this special care? Thirty-three percent of all patients on referral were newborns. All of the newborns referred had at least two of these problems; 33 percent of them were low birth weight infants; 16 percent of them had mothers under 17 years of age; 5 percent had retarded mothers; 4 percent had drug dependent mothers. Other problems also prevalent included in the mother — no prenatal care, preclampsia, and prolonged ruptured membranes. Problems seen in the children included congenital defects, children with small or large head circumferences, and children with diagnosis of sepsis at birth.

Most of the other children seen were initially referred from the pediatric ward. Again, general patterns of poor health-attitudes and difficulty with parenting were noted. Forty percent of all the children seen were between the ages of one month and two years. These children were most often referred (45 percent) with a diagnosis of psycho-social or environmental Failure to Thrive.

According to Doctor Sidney Gellis and Doctor Louis Barnett, 45 percent of all failure to thrive is due to ignorance or poor mothering patterns. Another 45 percent is due to intentional maternal abuse and neglect. Only the remaining 10 percent of failure to thrive infants have difficulties due to organic causes. Of the 30 children with failure to thrive referred through the At Risk Program only one had failure to

thrive from organic cause. With the failure to thrive (FTT) infant, care usually begins in the hospital. The FTT Protocol which involves a series of nursing guidelines, is initiated upon admission. The inpatient nursing staff and the physician work together to differentiate the child's problems through medical evaluation, observation of feeding patterns, and development assessment. Once organic cause is ruled out and the child demonstrates significant weight gain, Phase II of the protocol begins. The pounds gained in the hospital are not necessarily a measure of success. On the contrary, they can actively re-enforce parental feelings of inadequacy and further erode already low self-esteem in the parent.

Doctor Koel in a recent article stated "Fattening up puny infants is satisfying to the staff, but the child remains At Risk of subsequent violence if he is sent back to untreated parents." With this theoretical base active involvement of the parent in feeding and caring for the child begins. The child is not merely given to the parent to feed but active supervision by the nursing staff occurs whenever the parent is involved in the feeding process. Slow but continuous support and re-enforcement of feeding techniques and "mothering" are given to the parent until she or he is able to comfortably feed the infant. A number of these failure to thrive infants do demonstrate feeding difficulties such as frequent spitting, "cholesia," increased irritability, increased lethargy, and tongue thrusting. These problems, needless to say, are difficult to handle even by the most experienced mother. Imagine the impact of such difficulties with the young, insecure, emotionally upset mother with no external social or financial support. Specific techniques to handle such problems are taught. Following discharge the parent and child are followed closely through the At Risk Clinic. Continued emphasis on support in feeding and discussion of specific feeding patterns continues. Because the outpatient department receives information about specific difficulties in the hospital, along with a feeding schedule and evaluation of the parents, it is much more able to provide continuity of care.

The other significant group of children in this 0-2 year age group are the children with developmental delays. Again, much time must be spent with both parents and the child in evaluating their interactions and slowly demonstrating to the parent how more affective and appropriate ways of dealing with these problems can be found. Parents not only need help in accepting the children's limitations but often need continued support in handling such children. Readiness for referral is also to be emphasized in this area.

A number of these parents have been exposed to inappropriate parenting. The literature documents "physical abuse of infants is associated with the breakdown of motherliness." If the parent can develop confidence through repeated re-enforcement and practice of techniques of basic child care within a supportive structure, he may be more able to allow himself to feel the more subtle, but key ingredients of "motherliness" such as; tenderness, awareness, consideration of the needs of the infant, and responsiveness to him. Long-term feelings of isolation probably stemming from a parent's own childhood and the inadequacy felt by many parents increases both their need and demand of response from their infants and children. Unrealistic expectations of parents are dealt with at the individual's own level. Specific discussion and demonstration of child's needs and means of meeting such needs are commonplace in the Clinic. Continual re-enforcement and support of even the most basic concepts is a continual process. Even small strides must be met with positive re-enforcement in an effort to build a person's fragile self-confidence. These particular parents become overwhelmed easily so that the problem of caring for a child must be dealt with in parts.

As can be noted the majority of the children seen in the Clinic are under two years of age. Children between 2 and 16 years in At Risk Clinic have more chronic medical problems. Major categories of problems seen in the 2-6 year age group include malnutrition, congenital problems, and emotional problems in the children. Children between the ages of 6-16 years comprise only 18 percent of the total number of children seen, and their most common problems cited are chronic illness; specifically asthma, seizure disorder, cystic fibrosis, emotional problems, and minimal cerebral dysfunction, or learning disabilities. The seventeen-year-old teenager with a diagnosis of asthma; hypertension probably secondary to chronic glomerulonephritis; psycho-motor seizure disorder; moderate retardation; personality disorder; and pregnancy is a good example of the older child "At Risk."

3. The third objective is to identify areas of family stress. A number of stressful problems have been presented. Social and emotional problems also appear to predominate throughout the clinic population. Eighty-five percent (85%) of At Risk families have poor social situations; 12 percent of parents have serious emotional difficulties either of an overtly or borderline psychotic nature; and 90 percent of the families could be listed as multiple problem families. Parents who appear to be totally overwhelmed both emotionally and socially are obviously unable to hear medical recommendations, and least of all be able to carry through with them. They must be provided with increased support in social and financial areas in order to be able to cope with the medical aspects of care.

4. The fourth objective of the program is to facilitate referral and feedback as a result of referral. A great number of children are also being seen in other medical and social agencies within the city; 75 percent of the children attending the clinic are also being actively followed by the Public Health Department through public health nurses. Fifty to sixty percent of the active clinic patients are also followed by a caseworker at the Children's Protective Unit. Seventy (70%) percent of the children are being followed by some active welfare worker. Ten to fifteen percent of all children are referred to Children's Medical Center for further developmental evaluation or further psychological assessment. Review sessions which involve all professionals in the clinic are open to professionals from various other agencies who may be actively involved with clinic patients. Numerous contacts written and verbal are made with these agencies weekly.

5. The fifth objective involves accurate evalutation of level of safety between parent and child. The key to prevention of serious abuse, neglect, and failure to thrive is early detection. By early detection we mean numerous clues from both parents and their children that there may be a pending crisis. The availability of clinic personnel to these families at a time of crisis is essential. Clinic members attempt to work closely with others in the community involved with such families to aid in getting them immediate help. Each clinic member both individually and on a collective basis through review must make accurate judgments in terms of a family's ability to function as a unit in a safe and responsible way. The responsibility for making a decision about the family is accepted by the clinic. Referral to the Children's Protective Unit takes place frequently, for hoping that somehow they will become aware of this family without our verbal and written referral is hoping for the moon.

In general, in attempting to provide for the At Risk family with its multiple problems we must deal with a number of difficulties which are not strictly medical in nature. They must not only be dealt with but coordinated and integrated into the provision of care so that the family is not seen as an upper respiratory infection, or a diarrhea, but as a functional family unit. Although we have been in existence for a short time we are firmly committed to the fact that this type of a program works. It works because of interest, dedication, and willingness of all its participants to share both in the knowledge of the other and in the responsibility for the care of the generation of the future.

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OSMA JOURNAL / special

Sorcery and Scientific Medicine in Ancient Egypt

LOTFY L. BASTA, MD, MRCP, MRCPE, FACP, FACC

Ancient Egyptian medicine was pagan in some respects but surprisingly sophisticated in others. Surgical procedure and the scientific method were widely applied perhaps to a greater extent than we can ever know.

"The progress of science has rendered obsolete even those books that most helped that progress. As they are no longer of any utility, youth believes in good faith that they have never been of any use; it despises them . . . it laughs at them."

(Anatole France, The crime of Sylvestre Bonnard).

Ancient Egyptians called medicine the necessary art. They showed great interest in that art. They built the houses of life where physicians, priests and sorcerers learned the secrets of the art from its masters and teachers and where reference books were kept. Clemens Alexandrinus tells us that out of the 42 volumes that constituted the Egyptian encyclopedia at the University of Alexandria, six volumes were devoted to medicine. These volumes were destroyed during the burning of that university.

Today, the number of bonesetters, healers, and paramedical practitioners is considerable. If we gathered together current practices of official medicine, homeopathy, radiaesthesia, Christian sciences, yoga, cellular therapy, organotherapy, naturalistic medicine, acupuncture, the bonesetter, chiropractic devices, sympathicotherapy, phytotherapy and so on, this medicine would appear as a blend of hocus pocus and scientific method. So, was ancient Egyptian medicine with a difference of forty centuries. Through these centuries magical methods persisted alongside scientific progress. This was the case in ancient Egypt, as it was in Greece where as Hippocrates was writing his scientific treatises, the sacred snake was still worshipped and asclepions were being built in Epidaurus, Cos, Pergamon: This phenomenon, no doubt, could be still observed today.

Should we reassemble all the lost treasures, papyri, the houses of life, the Alexandria encyclopedia, we would be entitled to give an honest evaluation of what ancient Egyptian medicine was really like and on the place it occupied in the origins of modern thought.

Presented to History of Medicine Society, September 25th, 1975, during History of Medicine Lecture Series 1975-76, Goddard Auditorium, Oklahoma Medical Research Foundation, Oklahoma City, Oklahoma.

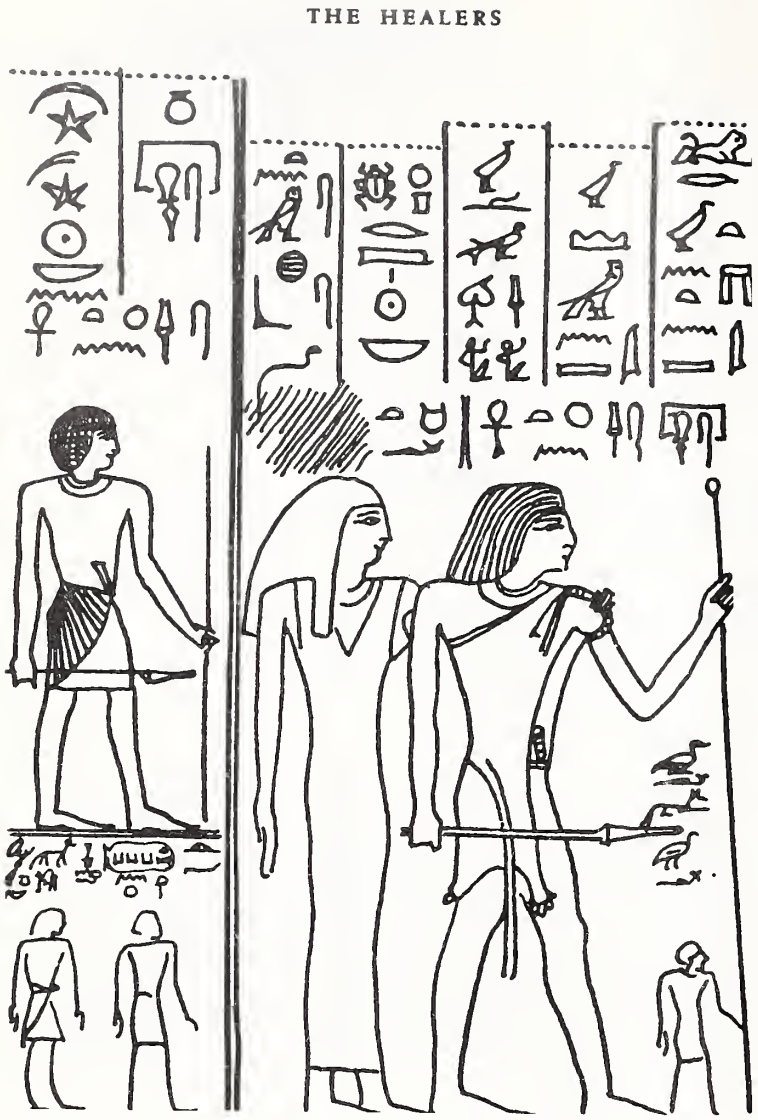


Figure 1. Ny-AnkSekhmet preceded by his son and followed by his wife, wearing a leopard skin and carrying a sceptre. He is also seen wearing an ordinary loin cloth to the left, top. Below him a man called "the man of the tooth."

Many texts are irretrievably lost, others possibly were never written because the masters would only transmit their teaching *viva voce*. Daumas emphasizes "For so much wealth to have been revoked at the hazard of excavations, considerably more riches must be presumed."

Physicians were regarded in high esteem in ancient Egypt. The slate given by Pharaoh Lahare as a gift to his beloved physician Ny Ankh Sekhmet (Fig 1) shows the physician standing with a sceptre in a position of command. Below him is seen a tooth man indicating a lower stature of that specialty at that time.

Ny's titles were "the noble governor, the God's son, and chieftain in the two lands, the Royal scribe, the one who is under the king, overseer of the Royal Harem, Chief Physician."

It is of interest to note that women practiced medicine in ancient Egypt. Pseschet was named "Lady director of the lady physicians." However, there is no evidence that any lady doctor took up obstetrics and gynecology.

Leclere relates that women entered this field of medicine when some Athenian women, disinclined to uncover to men their secret diseases, were compelled to seek the help of other women, against the old Athenian law which prohibited women from practicing medicine. But some women preferred death to delivery by men. One of them, Agnodice, disguised as a man learned medicine and helped her fellow women. When this was discovered, Athenians were compelled to change their law and admit women to medical schools. Specialization was prevalent in ancient Egypt. There were physicians for the eyes, teeth, abdomen, anus and for the unknown diseases.

The anus was considered important because it was the site of excretion of all waste, of piles, fissures and prolapse. A distinguished position in ancient times was the Royal Enema Maker. (Later to become the Iatroklystis in the Greek Civilization).

Many physicians held multiple specialties, veterinary and human. Several specialties had to do with gods, temples, etc, particularly when those gods were to control certain organs eg, the priests of Ny Ankh Dwaw were also occultists.

While the Greeks had only one god of medicine, Iscalapius, Egyptians had many gods; some of them caused disease, others helped in the cure.

SEKHMET: (Fig 2A) was called the Lioness of illness, destroyer of mankind. After she had accumulated tremendous power she could inflict disease or cause cure.

THOT: (Fig 2B) was referred to as the meas-

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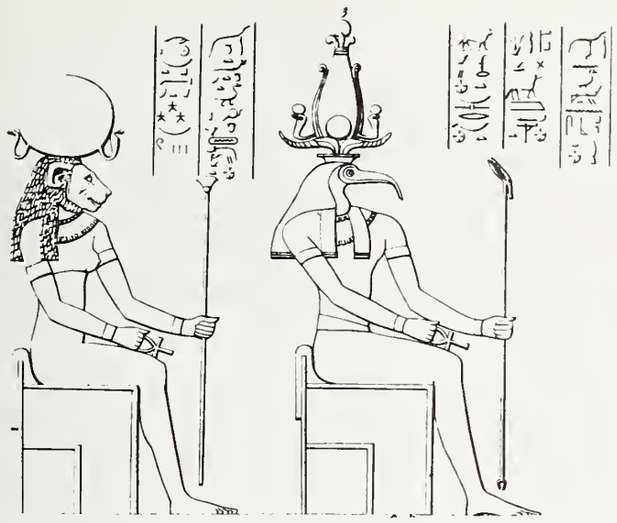


Figure 2. Left, Sekhmet (A) Right, Thot, the ibic-headed god (B)

urer, the creator of art and literature and the writer of Egyptian encyclopedia.

ISIS: Practiced magic before she became goddess. She performed the first resuscitation in history when she collected the parts of her beloved Isoris, and conceived from him. The product was another god, Horus: The god of the two eyes, one was the sun, the other the moon. He was the god of occultists.

TO-URT: The goddess of pregnancy was hippopotamus-shaped, capped with the disc, two horns and two plumes.

MERET-SEGER: The serpent goddess of the west was feared and worshipped so as not to inflict disease: "You mistress of the west, you made me see darkness in the fullness of the day."

There were many other gods; the chief of all gods was indeed Amen Re.

The sources of information about ancient Eygptian medicine include

1. The Greek Sources (Herodotus).
2. Archeology:

In the tombs, one finds illustrations of dwarfism, obesity, poliomyelitis, squint, hernia, gynecomastia, genital hyperplasia, leanness, emaciation and exophthalmos. Also, there are drawings of operations like circumcision, massage, orthopedic maneuvers, delivery and embalming.

It should be emphasized, however, that tomb art was aimed exclusively at providing material anlage for resurrection. The style and choice of vestiges had to be determined by the shape in which this resurrection was envisaged and, consequently, by imperatives of social status. As an example, Akhnaten and his family and the whole era of art show figures of Klinefelters Syndrome. It is probable, however, that that design reflected the bisexual nature of the god Amen Re who was worshipped during that era.



Figure 3. The priest Rom with atrophied and shortened right lower limb. Standing with the help of a stick, probably a sequel of poliomyelitis.

Kings and noblemen were usually figured in the healthiest and most beautiful shape for eternity, indeed without sacrificing resemblance which is a necessity so that the soul can recognize the body for the new life. While Septah had poliomyelitis as shown in his mummy, his limp was not portrayed in his tomb. By contrast Rom's figure shows talipes equinovarus most likely due to poliomyelitis (Fig 3).

Also, ancient Egyptians were "bon vivants" to the extent that after dinner (Herodotus) a wooden imitation of a decayed body was passed round the guests while saying "Drink and rejoice for you will be like this when you are dead." Nevertheless, we do not encounter fat pharaohs or noblemen's figures.

This was not true with the working class among whom foremen were usually fatter than laborers. Also the same did not apply to stran-



Figure 4. Chief Parihou and his wife, the queen of Punt presenting gifts to Hatshepsut. Steatopygy? Dercum's disease?

gers like Parihu and his wife the queen of Punt who had excessive adiposity. (Fig 4)

3. Mummies: showing diseases such as atherosclerosis, bilharziasis, traumatoloty, skull emptying techniques, trepanation, and methods of splinting.

4. Medical papyri: These were not written like textbooks but rather as descriptions of various medical practices prevailing at the time. There are nine of them that are known to date: Edwin Smith papyrus is the principal document on surgery in ancient Egypt; Ebers papyrus, the greatest document in pharaonic medicine; Kahoon papyrus, the book of women's disease and so on.

Nevertheless, our knowledge of ancient Egyptian medicine is far from being complete. Many documents have never been found, others like the Alexandria encyclopedia have been irrecoverably destroyed. Also a good deal of medical knowledge was kept secret as is seen from Ebers papyrus. "The secret remedy to the one who is under the physician except thine own daughter," a notable exception.

This secrecy continued till the Hippocrates era and was even carried to the Hippocratic oath "To impart precept, oral instruction and all the other learning to my sons, the sons of my teacher, and to pupils who have signed the indenture and sworn obedience to the physicians' law but to none other."

Healing in ancient Egypt was a blend of magic and medicine. Each of the two had its own pursuit but they were often used together for "Powerful are drugs over words and words over prayers." Ebers

The ancient Egyptian believed in certain concepts and principles:

1) There is immaterial and impersonal force permeating the universe. He invented the gods of provinces and the greater unique god of all Amen Re from whom secondary divinities descend.

2) The law of mystical participation: Mysterious ties hold things together in the universe and what is above is below. Indeed the Egyptian looked upon himself as a microcosm in the macrocosm in which souls and wills are related to objects or phenomena that permeate the larger macrocosm.

3) A system of logic based upon analogy and similarity. This system allowed him to deduce identity and solidarity between things from a resemblance in form, of name or from an entirely fortuitous allusion. Also, the name given at birth was believed to influence destiny as exemplified by Isis when she called her son Horus. This tradition was carried on to the Hebrews and Arabs. They believed that when two incidents followed each other in the past they will always maintain the same link which reminds us of some of our present superstitions such as Friday the 13th. Egyptians had many good days of the year when they were encouraged to do new projects and they had many bad dates when even the pharaohs would abstain from making decisions but spent the days in prayer.

4) Law of solidarity: by which the body remains eternally linked to its parts even if these parts were separated by accident or surgery.

5) Death is a protracted sleep during which the soul is set free to interact with other souls and powers until it reunites with the body.

From these concepts magic evolved and attained a tremendous power over man. In any day and age, magic has three components: the spell, the ritual and the sorcerer.

The *spell:* Ancient Egyptians attached tremendous power to the words written or spoken. Egyptians believed that anything that had no name did not exist. Sometimes important names were kept secret such as in the case of Isis with her father Re. When she wanted to know his secret name she compelled him to reveal it by having him bitten by a snake which she created . . ., "I let myself be persuaded by my daughter Isis. Let my name cross from my body to hers" whereupon she cured him. This reminds us of the fact that God did not reveal

his name to Abraham, Isaac and Jacob but revealed it to Moses (Exodus).

The *ritual:* was composed of acts or gestures accompanying incantations including tones, whistling, dramatizations, music, drugs, dance, pantomime or the use of water, oil, wine, talismans and amulets eg, elephant hair was used to prevent caries and bat's blood to cure night blindness. Oftentimes, it also included execution of frenzied characters or evil spirits.

"Retreat! Re is piercing thy head, splashing thy face, dividing thy head, crushing it in his hands, thy bones are shattered, thy limbs are cut to pieces."

Sorcerers: The prestige and power of the sorcerer was such that he was feared as much or more than the lay chiefs. Sorcerers were therefore chosen with utmost care, often since birth, from the nobilities or according to special signs. They were isolated, received very special education and spiritual training until they became endowed with super-powers.

It has to be emphasized that magic and religion, although often interrelated, have different paths. According to the Law of Moses "disease strikes man as the divine punishment of violation of morals or of ritual" eg Uziah stricken with leprosy when he disobeyed God. The priest helps to obtain the assistance of gods to cure disease through the pledge of the sick to submit to certain rules of behavior.

By contrast to the sorcerer, sickness results from the action of hidden forces with which he can contend. So while religions fight the devil with stronger spirits, magic contains these evil spirits through specific charms. But this distinction was perhaps not clear in the minds of ancient Egyptians and even today.

Of the influence of religion upon the Egyptians Breasted writes.

> There is no force in the life of ancient man, the influence of which so prevades all his activities as that of the religious faculty. Its fancies explain for him the world around him, its fears are his hourly master, its hopes his constant mentor, its feasts are his calendar and its outward usages are to a large extent the education and the motive toward the gradual evolution of art, literature, and science . . .
>
> Among this host of spirits animating everything around him, some were his friends ready to be propitiated and to lend him their aid and protection, while others with craft and cunning lowered about his pathway awaiting an opportunity to strike him with disease and pestilence, and there was no misfortune in the course of nature but found explanation in his mind as coming from one of these evil beings around him.

SCIENTIFIC METHOD

In the patient's workup, physicians were taught to deal gently and meticulously with their patients. Amenemope taught "Do not mock at the blind, do not scoff at dwarfs, do not injure the lame, do not sneer at a man who is in the hand of god." A suffering person was not be left alone, "Go on to him, and do not abandon him."

Also, the . . . "Prohibition to expose secrets or to look at women in foreign households" were clearly the forerunners to the Hippocratic oath.

In the patients' workup, there was a description of the general appearance and nutrition of the body, expression of the face, the color of the eyes, pigmentation and color of the skin, the state of consciousness and memory, detailed inspection of the face, its seven holes, the neck, abdomen and limbs. Swelling, shaking varicosities, perspiration and stiffness were noted. Smell of the body, of the sweat, breast, wounds, genitals, and excreta was described. Also, the smell of women's milk, when appropriate, was commented upon.

Urine and stools were then inspected: "Thou shalt rise every day to examine that which has fallen from his hinder part . . . if it changes from black bile to like porridge of beans thou shalt say to this: that which is in his cardia has come out."

Palpation of the pulse, "place of the heart," and of the abdomen was performed next.

"When any physician . . . applies the hand or his fingers to the head, the occiput, the hands, the place of the heart, the arms and the feet, then he examines the heart, because all his limbs possess its vessels, that is it speaks out of the vessels of every limb."

Percussion of the heart was probably known at the time: "Then thou shalt put thy hand over his cardia, if thou findest his cardia drumming and it is coming and going under thy fingers, and knock thy fingers with . . . ?"

Special maneuvers were then performed such as neck movements, leg movements in disease of lumbar vertebra and cough to increase the size of hernia.

In the patients' management, physicians were taught to differentiate curable, potentially curable from incurable disease:

Thou shoulds't say concerning him . . . one having . . . cure: "an ailment which I will treat"; possible cure: "An ailment with which I will contend"; or hopeless: "an ailment not to be treated."

Medical diseases

Heart disease:

Palpitations were described: "the heart goes up and down."

The first description of myocardial infarct is to be found in Ebers papyrus: "if thou examinist a man for illness in his cardia and he has pains in his arms, in his breast, and on one side of his cardia, it is death threatening him."

The ring finger was called the heart finger and Egyptians believed that there was a fine nerve connecting it to the heart.

Faintness was attributed to: "debility of the heart through heat from the anus."

Egyptians also described lung abscess, infectious heptatitis and acute abdomen. "Then thou shalt examine him lying extended on his back. If thou findest his belly warm and a resistance in his cardia thou shalt say to him: it is a liver case. Thou shalt prepare the secret herbal remedy which is made by the physician . . . if after having done that thou findest the two sides of his belly, the right one warm and the left belly cool, thou shalt say his liver has opened. He has received the remedy." (ie the remedy has worked).

They described under-nutrition, overeating and drunkenness.

They described worms such as ascariasis, severe anemia probably due to anklystomiasis and a disease called "aaa" characterized by ascites, gynecomastia and edema probably due to bilharziasis but they probably didn't identify the worms.

They also described endocrine disorders such as exophthalmic goiter, gynecomastia, genital hyperplasia, etc.

Eye disease was very common and blindness was very prevalent. One of the volumes of the encyclopedia of Alexandria was devoted to eye disease. Bat blood and urine, menstrual blood, lactating human milk and several chemicals including copper sulfate were used.

Anal disease had specialists since the anus was viewed as the site of excretion of waste products for every site of the body. Laxatives and a variety of formulae for enemas were popular. In the purification ceremonies people fasted, worshipped and had their insides cleaned.

Most of the medical diseases were however attributed to evil spirits and necessitated spells and magic along with therapy, herbal or otherwise.

SURGERY

With clean cut wounds, the lips were brought together with adhesive tape or by stitching. Other wounds were kept open. "Apply fresh meat on first day" (hemostasis?). In the following days: "astringent herbs and honey" (hygroscopic?) or moldy bread or moldy wood. (antibiotics?). Burns were treated with: honey, butter, oils, fatty substances, litanies and spells.

Depressed fractures of the skull were likened to a puncture in a pottery jar. Compressed fractures of the vertebral column were described as "the vertebra sinks into the interior of the neck as the foot settles in cultivated ground." Fractures could be distinguished from luxations by crepitus. Ancient Egyptians described dislocation of the jaw, fracture of the clavicle, traumatic hemiplegia, as well as aphasia and hyperacousis accompanying fracture of the temporal bone. Paralysis of the lower limbs and urinary incontinence were linked to fractures of the vertebral column.

Priapism and immissio seminis was noted with fracture in the middle of the neck. Squint and traumatic hemiplegia was attributed to skull fracture on the same side. The author of Ebers papyrus clearly realized the relationship between the CNS and voluntary movements and speech. This is remarkable since Hippocrates, a thousand years later held the brain to be a gland; and since the anatomical relations between the peripheral nerves and the nervous system were formulated only in the fourth century BC.

A vivid example of the scientific method is exemplified by this case of meningitis or, less likely, tetanus: "one having a gaping wound in his head, penetrating to the bone (and) per-

forating the sutures of his skull; the cord of his mandible is contracted; he discharges blood from both his nostrils (and) from his ears while he suffers stiffness in his neck, thou shoulds't say regarding him: 'An ailment with which I will contend.'

"If then thou findest that the flesh of that man has developed fever from the wound which is in the sutures of his skull, while that man has developed *ty* (probably meant pus) from that wound, thou shoulds't lay thy hand upon him. Shouldst thou find his countenance is clammy with sweat; the ligaments of his neck are tense, his face is ruddy, his teeth and his back (clenched), the odour of the chest of his head (scalp) is like the urine of sheep, his mouth is bound, both his eyebrows are drawn, while his face is as if he wept: 'An ailment not to be treated.' "

"If however, thou findest that that man has become pale and has already shown exhaustion thou shouldst have made for him a wooden brace with linen and put into his mouth. Thou shouldst have made for him a draught of fruit. His treatment is sitting between two supports of brick until thou knowest he reached a decisive point." Findings of bad prognosis were cited as: "unconsciouness, if his eyes are blood shot, he discharges blood from both nostrils, if the brain does not throb under the hand or if the bone sinks into the brain."

Careful analysis and followup foreshadow the Hippocratic method. This physician mentioned that if the patient survived the 14th day he is saved, probably referring to cases of tetanus.

The treatment of fractured clavicle and dislocation of the jaw were identical with subsequent descriptions by Hippocrates and were adopted for several centuries. For dislocation of jaw the Edwin Smith papyrus recommends: "thou shouldst put thy thumbs under the ends of the two rami of the mandible in the inside of his mouth and thy two claws (meaning two groups of fingers) under his chin, and thou shoulds't cause them to fall back so that they rest in their places."

Egyptians classified bone injuries into smashing, splitting, and piercing; Hippocrates gave a similar classification.

To diagnose sprain of a vertebra they advised that the patient be asked: "extend now thy two legs. He contracts them both immediately, because of the pain it causes in the vertebra of his spinal column in which he suffers." For fratures of long bones they devised splints of wood and linen, and padded with vegetable fibers.



Figure 5. Circumcision: Tomb of Ankh-ma-Hor. Right: the surgeon rubs in something with an avoid instrument. The patient says, "Rub well the part." Answers the operator, "I shall make it so that it is agreeable." Left: The cutting operator to assistant, "Hold him well, do not let him fall." Assistant: "I shall do what you will praise me for."

Femoral fractures often led to big callus and shortening indicating that bone traction was not practiced. Open fractures were usually fatal. For tumors, the surface and temperature were inspected carefully as well as the edge, consistency, and whether they were fluctuating, watery, fatty, pulsating or mobile with cough.

For example, in the description of sebaceous cyst: "if thou examinest a matter swelling in any limb of a man, and thou findest that its top projects and that it is joined and hemispherical, then thou shalt say concerning it: it is a swelling of matter that runs in the body, it is a disease which I will treat by an operation. There is something in it like viscous humor and afterward something like wax comes out. It forms a pouch. If anything remains in its pouch, it will return." Cancer and gas gangrene were also described.

Operative procedures: Ancient Egyptians used knives and scalpels heated in fire for cautery; hemorrhage was treated by cautery and bandage. Abscesses were opened.

Circumcision (Fig 5), tracheostomy and trepanation were known. Anesthesia was accomplished by opium and hyocyamus. The local anesthetic virtues of belladonna were probably known to Egyptians. They used for local anesthesia the stone of memphis with water, ground with vinegar; does the carbonic acid evolved have an anesthetic effect? Circumci-

sion was performed to remove the vestiges of the other sex (prepuce in male was considered to represent the female part, while the clitoris and labia minora in female were looked upon as representing the male parts).

GYNECOLOGY AND OBSTETRICS

Obstetrics was conducted primarily by the lay women in Egypt. The Bible mentions by name two Hebrew midwives practicing in Egypt with consent of the authorities (Shifrah and Puah). The sixth volume of the encyclopedia referred to by Clemens Alexandrius dealt entirely with gynecologic problems.

Pelvic anomalies were described as well as vesico-vaginal fistulae, rectal prolapse and perineal tears. Gynecologic examination reached as far as the uterus and included prolapse, papulous cervix and two cases of probably cancer of the cervix: "that which eats the womb and produces an ulcer." Leucorrhea was treated by pessaries and lavage made of plant medicine in beer. A syndrome of leukorrhea, inflamed eye and urethritis was noted. Was that the first description of gonorrhea?

Menopause was colorfully described: "*if* the woman passes many years without menses and her belly is as suffering from fire, it is rising blood from the womb. The patient doesn't have her bed and is apathetic due to inanition, terror or biting of the uterus."

In Kahoon's papyrus the fetus was thought to be composed of two portions: The mother provides the soft parts of the embryo's tissue and the father provides the bone. Semen was thought to be poisonous and the sperm was thought to ultimately come from bone; "fecundate women with the seed that comes from the bone." Thus the phallus and bone were believed to constitute the generative apparatus. "I bring the united phallus and spine that have been found in pkhety."

It is noteworthy that Hippocrates thought that the semen flows from the spinal cord, and the same concept was carried on by Galen for several centuries.

Tests of fertility were based on the demonstration of a free passage from vagina to the rest of the body such as vomiting after sitting on date flour mixed with beer or smelling for garlic or onion after placing it in the vagina. (This was acquired by Hippocrates and later the Arabs.) Pregnancy features in breasts, veins and colour of skin were carefully described.

To determine the sex of a child, ancient Egyptians believed that if the pregnant woman's urine germinated barley, it meant a boy. William Osler once said: "It takes ten years for a new idea to reach textbooks, but it takes a century to remove it." In this case it took three thousand years since the Germans used the same test until only recently.

There were rooms of birth in the temples. Childbirth was accomplished with the woman kneeling, squatting or sitting down on bricks. In ancient Egypt, they probably didn't tie the umbilical cord before cutting it. Precipitate labour was described.

Psychic illness was also known as exemplified in the following:

"Disease has sneaked into me
I feel my limbs heavy
I no longer know my own body
Should the master physicians come to me
My heart is not revived by their medicine
She is to me more than the sum of medicine"

In conclusion I would like to quote ptah/Heteps, the ancient Egyptian philosopher — "No artist attains total excellence. But the strength of Truth-Justice is that it lasts, and that man can say: this is the heritage of my father."

News From
The Oklahoma State
Department of
Health

The Control of Vaccine Preventable Diseases

The principal concern of the National Immunization Conference held in St. Louis, Missouri, March 1-4, 1976, was the occurrence of measles in highly immunized populations. It is abundantly clear that if an individual is susceptible to measles he is at risk of developing the disease following the appropriate exposure even though other persons in his immediate environment are immune. The occurrence of rubella in our high school and college populations dramatizes the futility of believing heavily immunized school age populations will remove the fear of rubella exposure from our child-bearing female population.

In order to prevent diseases like measles, rubella, tetanus, diphtheria, and pertussis the individual must receive the active immunizing agent. He cannot depend on his neighbor acting in his behalf. The reason polio has for practical purposes disappeared is the demonstrable spread of the vaccine virus in excreta. One should hasten to point out however, that low levels of polio immunization and isolated pockets of susceptibility will surely herald the recurrence of the disastrous disease.

The inescapable conclusion is that every susceptible person requires immunization if these diseases are to become insignificant medical problems. Will we accept the challenge of the immunization motto, "Every Child in '76"? Oklahoma has had a mandatory school immunization law since 1970. This law is flagrantly violated by the vast majority of school districts. Our children deserve to be protected and our society (parents, schools and governments) must get serious. Every child can be immunized within the constraints of parental consent. Are we willing to get it done? □

COMMUNICABLE DISEASES IN OKLAHOMA FOR MARCH, 1976

DISEASE	March 1976	March 1975	February 1976	Total To Date 1976	1975
Amebiasis	—	—	—	2	3
Brucellosis	—	1	—	—	2
Chickenpox	329	205	322	895	515
Encephalitis, Infectious	3	8	1	4	10
Gonorrhea (Use Form ODH-228)	1138	1046	1058	3322	2965
Hepatitis, A, B, Unspecified	106	87	169	536	256
Leptospirosis	—	—	—	—	—
Malaria	—	—	—	—	1
Meningococcal Infections	4	4	7	15	8
Meningitis, Aseptic	2	2	—	5	8
Mumps	193	24	114	384	56
Rabies in Animals	12	15	6	24	39
Rheumatic Fever	2	—	—	3	1
Rocky Mountain Spotted Fever	1	—	—	1	1
Rubella	7	10	11	31	56
Rubella, Congenital Syndrome	—	—	—	—	—
Rubeola	14	5	73	196	15
Salmonellosis	14	13	13	36	46
Shigellosis	42	19	9	66	139
Syphilis, Infectious (Use Form ODH-228)	11	7	11	35	29
Tetanus	—	—	—	—	—
Tuberculosis, New Active	34	43	26	84	88
Tularemia	—	—	—	—	—
Typhoid Fever	—	—	—	—	—
Whooping Cough	—	2	—	1	3

Is Public Relations the Answer?

An Interview With M. Joe Crosthwait, MD, Chairman, OSMA Council on Public Policy

By Richard L. Hess
OSMA Director of Communications

JOURNAL: Doctor Crosthwait, you have been chairman of the OSMA Council on Public Policy for about a year now. Has this year of experience provided you with any insight concerning any special problems which face the medical profession?

DOCTOR CROSTHWAIT: During this past year, I think that one of the most important realizations that I have become aware of is the really sad plight of the medical profession in the eyes of the public. I think we are really at the lowest ebb ever in the eyes of the public although we still rank above most other professions, I believe, including the clergy. Yet, our public reputation is at its lowest ebb ever. I think that most of these problems center around our always being on the defensive. We're constantly accused of not having any positive programs. We're constantly accused of having negative attitudes about everything and being against everything. I think this sometimes is true, but mostly, it has been one of necessity because we have been so busy fighting brush fires when we are attacked and trying to defend our position that we have had no opportunity to go on the offensive. It's my strong feeling, my strong opinion that the method we're going to have to use to keep from having to fight brush fires is a positive approach and one of being on the offensive rather than the defensive.

JOURNAL: In your opinion, is the medical profession's position generally a defensible one?

DOCTOR CROSTHWAIT: I think that there's no question that we are really in a good position to defend ourselves and this maybe is the problem we are having. We are trying to defend it when in reality it is a defensible position and, therefore, we must take the story to the public. We must show the public that the charges that are leveled against us by special interests groups and by third parties who have promised more than they can pay for are basically untrue. In positive ways we must point these things out.

The utter confusion of the federal government itself and for that matter, all third party intervenors, is indefensible. It is such that their main goal is to control medicine. Many consumer groups are made up of people who are either unknowingly tools of the socialists or I think that many of them admit that they are socialists. Their main thrust is to do away with anything that is capitalism and, of course, the practice of medicine is a capitalistic approach to services for people. I don't think we really have to defend ourselves, and I think this is where we continue to get ourselves in trouble.

"I really think that we should tell our story, not in a defensible way, but I think in a positive manner; it will defend itself."

What I would envision as a long range policy is for the Public Policy Council to begin a long range program with certain priorities to point out to the general public that the vast majority of individuals who are in the health care fields and particularly those who are physicians are not subject to dishonest activities, to double billing or to fraudulent billing. They have only been able to implicate three or four percent of the doctors in this country with any illegal or dishonest activity. Of course, the third parties of the federal government and the consumer groups try to use this three or four percent to damn us all. I think if you can really compare what has happened in other professions and certainly in the field of politics, I would say that other professions would have to be proud of that kind of a record.

I really think that we should tell our story, not in a defensible way, but I think in a positive manner; it will defend itself.

JOURNAL: So your idea of public relations is to take a positive position and do the work before the crisis hits?

DOCTOR CROSTHWAIT: That's true; there's no question about it. When you look at the charges that are leveled against a profession that has provided the greatest medical services the world has ever known, it is almost unbelievable. We have provided the greatest scientific medical progress the world has ever known, and we have done this under a free enterprise system. When you recognize that the medical profession in the last few years has been stymied in many ways, simply because of most times idiotic rules and regulations affecting the medical profession in its entirety, hospitals and doctors alike, it becomes obvious that there is no way the medical profession with the increased interference of rules and regulations by third parties is going to be able to continue at the same progress we have had in the last 100 years. We must take a firm, positive stance now and prevent future intervention.

JOURNAL: Doctor Crosthwait, do you believe national health insurance would be in the public's best interests?

DOCTOR CROSTHWAIT: Certainly, I feel that any type of national health insurance would be a disaster to the health care of the people in the United States. I think it is proven that beyond any reasonable man's doubt that the once great nation of Great Britain has been brought to its knees by a social program called their national health service. I think this would do the same thing to this country, and the health care in this country would deteriorate to the point that people would not tolerate

"I think that we need to, number one, keep an ongoing program to the doctors themselves . . ."



M. Joe Crosthwait, MD, a Midwest City physician, has served as Chairman of the OSMA Council on Public Policy for the past year. He was also elected OSMA Vice-President at the 1976 annual meeting in April.



Doctor Crosthwait is a strong advocate of the free enterprise system and endorses public relations as a tool for preventing intervention into the practice of medicine. The Journal arranged this interview in order to discuss public relations and the future of medicine as Doctor Crosthwait sees it.



"I think we are really at the lowest ebb in the eyes of the public . . ."

it. We're used to good health care; we're used to the availability of good health care. I think that if the story were told to the American people of how the national health insurance program came about in Great Britain and what it has done to a once great nation, I think that they will want no part of the social planner's scheme of so-called free health care. There is nothing free! Santa Claus is dead and you get nothing for nothing! Somebody has to pay the price for everything! There is no way that you're going to be able to send a $100 billion to Washington and get back a $100 billion of health care. By the time the social planners get through with it there will be $50 billion left and they'll be asking for another $50 billion to make up the difference. There is no question in my mind that if we really want to bankrupt this nation, then we should embark on more socialistic programs such as national health insurance.

JOURNAL: Should then, part of the association's public relations efforts be concerned with warning the public about N.H.I.?

DOCTOR CROSTHWAIT: I think it must be. You know, most people's opinions are formed by a third party — the media, some type of media, either through the newspapers or television. When people come home from a day's work, they really don't want to sit down and study whether or not national health insurance is good for them. They really don't want to have to sit down and study all the medications that might be useful for the case of indigestion they have at the moment. So it is such a relief to men to have the media come on the tube with the picture of a man having severe indigestion, show a glass of water and a pill dropping in the water which fizzes, which he drinks,

"I feel that any type of national health insurance would be a disaster . . ."

and suddenly, within a course of 15 seconds, he's well and ready to go to another party. This is the type of solution that the general American public wants. I think the thrust toward any of these programs is usually brought on by some type of media.

When CBS decides that there is a course of action they want the American people to take, they do a documentary. They show all the pitfalls; they very carefully edit out all of the strong points or anything that may be against their position; they edit that out of the film and continue on. They are opinion makers! They make our presidents; they make our vice-presidents. They decide if there is a certain senator that they want out of office, and if they do, it is very easy for them to do it. They can form opinions simply by a 30-minute or an hour documentary. I think this should be our ap-



". . . their (the federal government's) goal is to control medicine."

proach. I think our approach should be through the media, and I think it should be a simple approach, one that shows the people, the problem, and a reasonable solution. Above all, the idiotic rules and regulations that are coming out of Washington should be dealt with. They are affecting every profession and occupation in the country, making every other type of service and product much more costly simply because of the rules and regulations that many times have no basis or fact.

JOURNAL: When we start discussing ambitious media campaigns, one of the first arguments brought up is, "That's a job for the AMA." Do you agree?

DOCTOR CROSTHWAIT: I agree ideally, that this should be a program on which the AMA should embark. The AMA, however, has shown no inclination in trying to do what I am talking about. They have shown no inclination of going to the media and demonstrating the things that I have talked about. So I think that

". . . most people's opinions are formed by a third party—the media . . ."

if we want it done, I think that we must do it ourselves. It's going to cost some money; there's no question. It will cost money, but I would like for you to realize that even with our increase in dues across the board, our dues to our organization are still less than a truck-driver pays to his union for his benefits from the union each year. I think, certainly, that if we expect to continue to have our freedom as private practicing physicians or at least physicians without so much third party interference so that we can continue to practice good medicine, whether it be in private practice or in hospital practice, then I think we're going to have to pay the price to protect our image. I'm also convinced that there are other county and state organizations which would like to do the same thing that we're talking about here today. They have had no one to take them by the hand and to show them the way. I hope that we'll be able to find the way to be able to get our story across to the American people. When we do, then we'll find colleagues and allies in other county and state medical societies who will not only want the end product of our labors but will also help us financially pay for it. So I look at the investment in a public relations program as being an initial capital investment, not as a long term total cost each year. I think that we can start and come up with a good building and we'll be able to find plenty of renters to take space in that building.

JOURNAL: Would you please explain the action taken recently at the annual meeting which gave the Board of Trustees the authority to assess the OSMA membership for public relations.

DOCTOR CROSTHWAIT: I was very gratified that the Reference Committee made the recommendation which was passed by the House of Delegates. They made a recommendation that the Board of Trustees be empowered to level an assessment upon the membership of up to $100 for the specific purpose of public relations. I don't know what the cost is going to be at this time. I do know that I intend to, as chairman of the Public Policy Council be as prudent as possible and to get the most mileage from every dollar that we spend. I do believe that we are going to have to start out and engage in a sophisticated system of telling our story. It can't be on a crash basis or on a crisis basis. This seems to be what we have done in the past. Every effort was either a crash program or a response to a crisis. It must be a total ongoing program with ideas that extend into the next two or three years rather than just a six-weeks program of telling everybody how good their doctor is. I think that one of the approaches that we might use is a documentary film showing medicine as it is practiced in Oklahoma. We could do this by



"We have provided the greatest scientific medical progress the world has ever known."



"We must take a firm, positive stance now and prevent future intervention."

talking with patients about the type of care that they obtain from their doctor, talking with patients who have been to hospitals and put this out so that the people can recognize that medicine today is probably still the greatest bargain in the country.

JOURNAL: A very important part of association public relations is certainly internal. Has the Council on Public Policy initialed any such campaigns during the past year or so?

DOCTOR CROSTHWAIT: I think that one example, and again, an example of our functioning in a crisis was our little pamphlet on the rollback of Medicare fee reimbursements. This, of course, caught us at a time when we were really not ready for it, but fortunately we were able to get a pamphlet out to all the doctors for a stuffer in their bills and to present to their patients, explaining that this rollback in fee reimbursement was not due to anything that physicians had done but rather to what the federal government had done to their Medicare and Medicaid schedules themselves. They had cut the patients back and were reimbursing them less than they did before. The doctors' fees had not risen; they were just reimbursing less. From the studies that we have been able to accomplish, no patient has complained to his doctor that they weren't getting their fair share from the doctor regarding the Medicare reimbursement fees. I think that we need to, number one, keep an ongoing program to the doctors themselves and particularly the doctors' offices, so that their secretaries, receptionists, and nurses will know what's going on and be versed on how to answer questions. Our medical profession itself is really not up to date on what is happening to them so far as rules and regulations are concerned. We need to keep them apprised of what's going on. As you know, we are in the process of mailing information placards to doctors which they'll be able to keep in their offices to explain current medical issues. We hope this will give the doctor an opportunity to get through to his patients some of the important problems of medicine and some of the important third party rules and regulations that are not only affecting the quality of their care, but also the quantity of their care and the cost of their care. Another project that I think was very important was the "Malpractice Update" and the final passage of Senate Bill 622. I think this exemplifies the method which we were able to use to mobilize our forces to accomplish a specific objective. "Malpractice Update" went out almost weekly to educate our members about what was going on in the Senate and House of Representatives. To me the fact that the vote in the Senate was 42-1, and the vote in the House was 88-3 really exemplifies what can be done in a mass effort. I think this was amply handled by David Bickham and the Legislative Committee and with the Update; it was a massive program to educate not only our doctors and patients, but also to educate our legislators. I don't think that this is something

". . . our dues to our organization are still less than a truckdriver pays to his union . . ."

that should be such a novelty; I think that we can do this almost on a daily basis if we would just prepare our people.

When we talk about public relations, public relations is not going to the people for help when you're in trouble. Public relations is letting the people know what kind of an individual you are so that when a problem exists, you don't have to go beg for their support; they're anxious and willing to help in any way possible. This is why I think that we should do



". . . the expense of any health care is going to rise in direct proportion to the involvement of third party intervenors."

our spade work ahead of time. We need to enlist the people and get the people on our side and realizing that they do have the greatest health care in the world and that the more it's tampered with by third parties, the less quality health care will be available to them. They need to realize that the expense of any health care is going to rise in direct proportion to the involvement of third party intervenors.

JOURNAL: Often, one of the major obstacles which must be overcome by a public relations counselor is a "lost" or helpless feeling by the company or association. So you believe public relations can really be effective?

DOCTOR CROSTHWAIT: I certainly don't think it's hopeless at all. I think that these things that we just pointed out have been examples of what can be done, if the program is well-planned and well-executed. Now I think if we continue to try to do things on the same basis that we have for years and that is trying to defend a position only when we're in trouble, then I think we're going to continue to have almost total failures and our public relations program will be a failure. It need not be a failure if we do our homework before, if we do our planning well, and if we have the backing and support of our own members. I think that we can do a very effective public relations program so that we're not constantly fighting and trying to say, "No, we're good guys. We're just being maligned." This is not a positive approach.

JOURNAL: What role can the physicians across the state play in improving the profession's image? Does the individual physician have a role?

DOCTOR CROSTHWAIT: I think so; I think that some of the most important things that we are constantly being accused of is not taking care of our patients. Most of this is not because we don't take care of our patients, it's just that we don't explain to them that we are taking care of them. We're busy; we're all busy! We have problems finding time to accomplish the things that we need to accomplish and take care of our patients, do our hospital committee work, our medical association work, and we don't take the time to stop just a minute and say to our patients, "Now this is what we're doing and why we're doing it."

One of the basic reasons that we have so much trouble with malpractice is that we have lost contact with our patients. When we're too busy to sit down and establish a good public relations policy with our own patients, then this carries on through to the entire profession. That in itself is an indefensible position.

I really believe that our Public Policy Council can be effective. I think it can be successful. I think our public relations policy can be successful. With the cooperation of our members, the financial backing of our members, and the help of our members, we can continue to take good care of the health of the American people. □

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1976 Annual Meeting in Brief

For the first time since the Oklahoma State Medical Association became involved in Oklahoma Medical Summit, the annual meeting was held apart from the scientific sessions. The meeting proved to be, nonetheless, one of the most active and important in the association's history.

One of the most important topics considered at the meeting was continuing medical education and whether it should be required for the membership in the OSMA. By an overwhelming vote, CME was approved as a requirement for membership in the state association.

According to action taken by the OSMA House of Delegates, in future years Oklahoma doctors will need to attend continuing medical education courses in order to insure their continued membership in the OSMA. The House of Delegates instructed the Council on Continuing Medical Education to develop the criteria and accreditation procedures. The OSMA will form an official accrediting body in cooperation with the University of Oklahoma Health Sciences Center, the Board of Medical Examiners, the Foundation for Peer Review, the Oklahoma Academy of Family Physicians, and other medical organizations and specialty groups.

The CME plan will be presented to the House of Delegates at its 1977 meeting and will be implemented in January, 1978. The first three-year period will conclude in December, 1980.

In other action, the Delegates also voted to make membership in the American Medical Association voluntary for the first time in OSMA history. Before the April action by the House of Delegates, Oklahoma was the only state to have had mandatory AMA membership since that organization first charged dues in the 1950's.

According to the action taken by the House of Delegates, as of January 1st, 1977, membership in the AMA will no longer be required for OSMA members, although the dues paid for membership in the two organizations will remain the same. Each OSMA member will be able to decide if he wishes to belong to the AMA. If he chooses not to belong, the dues that would have gone to the AMA ($250) will be apportioned equitably, between the county medical society and the OSMA.

Officers for 1976-1977 were also elected at the annual meeting. Those elected are C. S. Lewis, Jr., MD, Tulsa, President-Elect; M. Joe Crosthwait, MD, Midwest City, Vice-President; S. N. Stone, MD, Oklahoma City, Speaker of the House of Delegates; Jack D. Fetzer, MD, Woodward, Vice-Speaker of the House of Delegates; Harlan Thomas, MD, Tulsa, AMA Delegate, Position I; Orange Welborn, MD, Ada, Alternate AMA Delegate, Position I; Scott Hendren, MD, Oklahoma City, AMA Delegate, Position II; and Rex E. Kenyon, MD, Oklahoma City, Alternate AMA Delegate, Position II.



New OSMA officers are from left to right M. Joe Crosthwait, MD, Vice-President; Orange M. Welborn, MD, President; and C. S. Lewis, MD, President-Elect.

Doctor Welborn and the other state medical association officials were officially installed at a May 8th inaugural dinner held during Oklahoma Medical Summit '76. □

Attorney General Opinion

In a decision handed down in early May, the Oklahoma Attorney General ruled that a pardoned felon is not eligible to take the examination for a license to practice medicine in this state.

Attorney General Larry Derryberry said in the opinion that while a pardon does restore a convicted person's citizenship rights, it "does not rehabilitate the character" of that person.

The Attorney General's opinion further stated that the State Legislature could have given the Board of Medical Examiners discretionary powers in such matters, but had not done so. The rules state than an application for a license to practice medicine must not have been convicted of a felon. □

ANNUAL MEE



One pleasure at any annual meeting is the presentation of awards to deserving persons. Doctor Nelson is shown here presenting a Distinguished Service Award to George H. Garrison, MD, (above) for his years of exemplary service and dedication to the profession and to his patients.

R. Barton Carl, MD, (below) is shown here after receiving an award for his seven years of service as chairman of the OSMA Legislative Committee. Doctor Carl is stepping down after a successful year highlighted by passage of SB 622.





AMA Trustees Lowell H. Steen, MD, and Joseph Boyle, MD, (from left to right) are pictured here with David B. Weihaupp of the AMA staff. Doctors Steen and Boyle were speakers at the OSMA House of Delegates meeting.

G IN PICTURES

Although no one seemed surprised, David Bickham, (below), OSMA Associate Executive Director, is obviously pleased to receive an award for his hard work in gaining the Legislature's approval of SB 622.





Arnold G. Nelson, MD, (left, above) OSMA President, is shown here presenting Kent Braden, MD, with a Distinguished Service Award for his service as Chairman of OMPAC. Doctor Braden was honored for his principled and uncompromising leadership.



Mrs. William B. Renfrow presents AMA-ERF checks for $22,160.74 and $2,111.00 to Thomas Lynn, MD, Dean of the University of Oklahoma College of Medicine.



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OSMA Endorsed Malpractice Measure Now Law



Governor David Boren signs SB 622 into law . . .

SB 622, which has now been approved by both Houses of the Oklahoma Legislature and signed into law by Governor David L. Boren, is the result of more than two years of painstaking research and drafting. During its various sessions it has been written and rewritten, drafted and redrafted in an attempt to allow input from all interested parties. In essence, it is not just a bill sponsored by the Oklahoma State Medical Association, but rather a cooperative effort of doctors, nurses, pharmacists, patients, and lawyers. It is a bill that should prove to be of great value to every person in the State of Oklahoma.

Approximately two years ago, state medical association officials recognized that the spiraling medical malpractice crisis previously found only in the eastern and western coastal states, was beginning to creep inward toward Oklahoma. In those states where the crisis had hit hardest, doctors found themselves either paying exorbitant premiums for their insurance or they were unable to buy adequate coverage at any cost. The problem was beginning to compromise the physician's ability to provide medical care, and indeed, threatened to jeopardize the entire profession. In order to prevent this from happening in Oklahoma, preliminary work on SB 622 was begun well in advance.

Although physicians in this state still have what must be considered one of the best professional liability insurance programs in the nation, premium increases are nonetheless beginning to affect the Oklahoma doctor. In 1976, the cost of carrying one million dollars in insurance rose approximately 100 percent. The affect SB 622 will have upon the cost of insurance and its availability is not yet known. OSMA officials are, however, enthused about the bill which is one of the most equitable and promising pieces of legislation passed by any state.

SECTION 1: Claims Reporting System

This section provides for a claims reporting system which has never before existed in the State of Oklahoma. Its intent is to make more detailed information regarding malpractice suits and their disposition available to both licensing boards and the leaders of the House and the Senate. It provides that whenever a claim is filed against any "practitioner of the healing arts" or a licensed hospital, the liability insurer will report the claim to the licensing board within 60 days. If the party being sued is not insured, he or she will be responsible for filing the report. The report will include the following items of information:

1. The name and address of the practitioner or hospital;
2. The name, age, and address of the claimant;
3. The nature of the injury, illness, or condition complained of; and
4. Whether a suit is pending and if so, the court and docket number of the action.

Based upon this information, the licensing board will be able to take any remedial or disciplinary action it believes is necessary. An annual condensed report will also be provided to the President Pro Tempore of the Senate and Speaker of the House. This condensed report will not include the names and addresses of the parties involved.



. . . and returns the pen to R. Barton Carl, MD, Chairman of the OSMA Legislative Committee.



Afterward, the Governor congratulates Doctor Carl and OSMA Associate Executive Director David Bickham . . .

SECTION 2: Statute of Limitations

This section will in effect close the open-ended statute of limitations which previously existed for medical malpractice lawsuits in this state. Before SB 622, no real statute of limitations existed since the patient had two years from the date of discovery to file a lawsuit. In effect, this meant that a legal action could be brought 20 years or more from the date of the alleged occurrence, and, therefore, insurance companies never really knew what their losses were. This made professional liability insurance an actuarial guessing game and added to an insurance company's credibility in asking for premium hikes.

This section now provides that any action for damages must be brought within two years of the date the plaintiff knew or should have known of his complaint (discovery). It further provides that no action may be brought more than three years from the date of the occurrence *except to recover actual medical expenses.* This not only means that doctors and their insurers will no longer have to face the extreme tail-time involved with professional liability insurance, but it also means that Oklahoma will have a unique statute of limitations.

SECTION 3: Waiver of Privilege

In the past, professional liability defense attorneys have been unable to obtain detailed information regarding the plaintiff (patient) and his treatment because of the privileged status of patient records. Defense attorneys before were unable to talk with other physicians who were involved in a treatment procedure, and they were unable also to obtain relevant information about the plaintiff's medical history. Under this section, once a patient places his physical or mental condition in issue by filing a lawsuit, this privileged status is automatically waived. The defense attorney can then apply to the court where the action is brought for information which is relevant to the case in question. If the court decides that the information is relevant, it will then be provided. This section will not only do away with some of the inequities in defending a malpractice lawsuit, but it will also help pinpoint non-meritorious suits and keep them out of the courts.

SECTION 4: Non-Compliance Penalty

Section 4 simply provides that failure to comply with the provisions of Section 3 (the waiver of privilege section) will be a misdemeanor offense.

SECTION 5: Res Ipsa Loquitur

This section both clarifies and qualifies an often misused doctrine of law — Res Ipsa Loquitur. Literally, this means "the thing speaks for itself," and often implies guilt in a medical malpractice case even before the facts are presented.

The reasoning behind this doctrine is that in some cases, the mere occurrence is enough to show that negligence has taken place. Thus, "the thing speaks for itself." One particularly appropriate medical case involved a patient who suffered a broken bone while being turned in bed. Logically, to a lay jury, being turned in a hospital bed is not a dangerous event, and the risk of suffering a broken bone as a result of this event should not exist. On the basis of this doctrine, the lay jury was inclined to find the defendants negligent and to assess appropriate penalties. In this particular case, however, extenuating circumstances existed and "expert testimony" pointed out that the patient suffered from osteoporosis. So in this particular instance, due to this particular condition, expert testimony was able to show that negligence did not take place.

Under SB 622, Section 5 provides that a presumption of negligence shall arise if these facts are first established:

1. The plaintiff sustained an injury;
2. The injury was caused solely by the defendant; and
3. Such an injury does not normally occur absent negligence.



. . . and then turns to discuss the malpractice measure with authors Senator James Hamilton, Representative David Craighead, and Senator Bob Funston.

Under SB 622, if the court feels that the information or knowledge necessary to make this judgment is not possessed by the "average person," then these foundation facts must be established by *expert testimony*.

Section 5 will provide the jury with more detailed and specific information concerning medical malpractice lawsuits in which Res Ipsa Loquitur is applied. It will in fact put "all of the information" before the jury and prevent a presumption of negligence when it should not occur.

SECTION 6: State Insurance Fund

With doctors and hospitals finding it more and more difficult to get adequate insurance coverage, Section 6 will provide some possible relief. Ten years ago, over fifty companies wrote either basic malpractice insurance or the excess limits plan. Today, there are only six. The Insurance Company of North America, which writes basic coverage for Oklahoma doctors, has pulled out of the market completely except in the State of Oklahoma. Additionally, there is some doubt as to how long Continental National American will continue to write excess limits coverage in this state. At this point, if either of these companies withdraws from the Oklahoma market, there is no company ready to take its place.

Section 6 authorizes the State Insurance Fund to offer malpractice insurance and/or reinsurance to Oklahoma doctors and hospitals. Under this section such insurance can be offered once the State Board of Property and Casualty Rates gives its approval. The Board's approval would be based upon whether or not offering such insurance would be in the "public's best interests," and whether or not it was actuarily sound. □

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Psychology Training Regulations Explained

DONALD J. BERTOCH, PhD, Chairman
State Board of Examiners of Psychologists

EDITOR'S NOTE: The following article is being reprinted at the request of the author.

This brief article is to inform physicians in private practice about certain aspects of the Psychologists Licensing Act of 1965. The reason for bringing this to the attention of physicians is that over the past two years the State Board of Examiners of Psychologists has received numerous inquiries expressing concern about psychologically-trained but unlicensed persons working with, and/or employed by, medical doctors in group or individual private practice. Under the law, (Title 59.O.S. 1971 Supp. Sections 1351-1375) such unlicensed persons must be approved for rendering psychological services by the State Board of Examiners of Psychologists.

The act defines a psychologist (sic) " a person represents himself to be a psychologist when he holds himself out to the public by any title or description of services incorporating the words 'psychology', 'psychological', 'psychologist', and/or offers to render or renders services to individuals, corporations or the public for compensation." (#1352b)

The practice of psychology is defined as including, but not restricted to, "counseling with persons or groups with adjustment problems in the areas of work, family, school, and personal relationships; measuring and testing of personality, intelligence, aptitudes, emotions, public opinion, attitudes, and skills; and doing research on problems relating to human behavior." (#1352c)

The law provides for certain exemptions to the above, one of which is directly pertinent to physicians, notably those who specialize in psychiatry:

"After the first day of Jan. 1966, no person may represent himself to be a psychologist or engage in the practice of psychology unless he is licensed under this act except as hereafter provided:

"(d) The activities and services of a person who performs psychological services under the direct supervision of a licensed psychologist or psychiatrist, provided however that such person shall be subject to Board approval, and for whose activities and services the licensed psychologist or psychiatrist assumes full responsibility." (#1353)

It is hoped that the quoted text may clarify for physicians the pertinent elements of the licensing law. It also points out the necessity for the physician, wishing to have psychological services available in his practice, to inquire about the legal qualifications of individuals who claim to be completely qualified for rendering psychological services in a private medical practice setting.

Anyone interested in obtaining a copy of the Psychologists Licensing Act and a list of currently licensed psychologists may write or phone the Board's Executive Secretary, P.O. Box 53392, State Capitol Station, Oklahoma City, 73105, Telephone (405) 271-6118. □

AMA Annual Convention Set June 26th In Dallas

The 125th annual convention of the American Medical Association will be held June 26th-July 1st in Dallas.

The complete program for the convention was published in the April 19th issue of JAMA.

The convention will include special lectures, postgraduate courses, scientific exhibits, medical motion pictures and other activities designed to further the continuing education of physicians.

In addition to the scientific program at Dallas' Convention Center, the House of Delegates, the AMA's policy-making body, will convene in the Fairmont Hotel for its semi-annual session. The House includes 256 delegates, representing each of the state medical societies and the scientific specialties, plus the military services and the federal government. Interns, residents, and medical students now have official representation in the policy body. Oklahoma has three AMA delegates.

More than 50 postgraduate courses will be offered, covering the complete range of medical practice. Subjects will include diagnosis and treatment of various types of cancer, surgical suturing, important treatment developments of the past ten years, human sexuality, injuries of the hand, urology, eye problems, care of the burn patient, neurology, head injuries, occupational medicine, dermatology, kidney disease, orthopedics, exercise in treatment of heart dis-

ease, diabetes, anesthesiology, antibiotic therapy, a biofeedback training course, lung disease, allergies and both basic and advanced training in resuscitation of the heart attack victim.

General lecture sessions will cover topics such as the federal thrust in primary health care, influence on the practice of medicine of government regulation of drugs, and contemporary nutritional therapy. Special topics will include sessions on pets and human disease, cystic fibrosis, and on prescribing of antibiotics in everyday practice.

The 18th National Conference on Medical Aspects of Sports will be held on the opening day of the convention, June 26th.

The 53rd annual convention of the AMA Auxiliary will be held simultaneously with the general convention. The program will be a combination of business sessions, educational programs and social events for physicians' wives.

The American Medical Golf Association will hold its 50th annual golf tournament June 28th at the Brook Haven Country Club in Dallas. The American Physicians Art Association will sponsor the annual exhibition of paintings, sculpture and other art works by physicians at the Convention Center. Awards will be presented for outstanding work in the arts. □

Hoffman Named To Assistant Chief Medical Examiner Post

A. Jay Chapman, MD, Chief Medical Examiner for the State of Oklahoma, has announced that Neil A. Hoffman, MD, assumed full responsibility for the functioning of the Eastern Division Office of the Chief Medical Examiner in Tulsa.

Doctor Hoffman received his medical degree from Wisconsin in 1967 and took an anatomical pathology residency at Barnes and Allied Hospitals and Washington University School of Medicine in St. Louis and a forensic pathology residency at Case Western Reserve School of Medicine in Cleveland. He has most recently been serving as Associate Chief Medical Examiner for the State of North Carolina as well as handling teaching responsibilities in the Department of Pathology at the University of North Carolina at Chapel Hill. Board certified in forensic pathology, Doctor Hoffman assumed his duties in Oklahoma on April 1st. □

DEATH

JOHN F. KUPKA, MD

1903-1976

A retired, 73-year-old Haskell general surgeon, John F. Kupka, MD, died March 31st, 1976. Born at Fairbault, Minnesota, Doctor Kupka was graduated from the University of Tennessee College of Medicine in 1932 and established his practice in Haskell in 1935. He retired in 1965. Doctor Haskell was a Life Member of the Oklahoma State Medical Association. □

Book Reviews

MEDICAL EXAMINATION REVIEW BOOK Volume 30 Infectious Diseases, Martin J. Raff, MD. Published by the Medical Examination Publishing Company, Inc., 1974. Pp. 189.

This book contains almost 1,300 multiple choice questions of varying difficulty on basic and applied microbiology and immunology. It covers common as well as unusual infectious diseases and their therapy. The answers are referenced with current literature citations. It will be useful to instructors dealing with clinical microbiology and infectious diseases. *Harris D. Riley, Jr., MD*

BEHAVIOR DISORDERS IN CHILDREN Edition 4. By Harry Bakwin, MD, and Ruth M. Bakwin, MD, Philadelphia, W. B. Saunders, 1972. 714 pp. $17.50

This is the fourth edition of this well known text. Among the book's genuine assets are its breadth and scope, its clinical orientation, its readable format and extensive references. The limitations continue in this edition. The authors have never stated for whom their text is intended. No theoretical framework of child development and its disturbances are presented. In many cases, discussion of clinical problems and issues are rather disjointed. The use of psychotherapeutic agents is dealt with in a rather non-specific and loose manner.

Despite its shortcomings, it will continue to be a widely used reference. *Harris D. Riley, Jr., MD*

DIAGNOSIS AND TREATMENT OF FUNGAL INFECTIONS, Edited by Harry M. Robinson, Jr., MD. Published by Charles C. Thomas: New York, 1974. Price $29.50, Pp. 560.

This book consists principally of papers presented over the past few years at symposiums on fungal infections conducted at the annual meetings of the American Academy of Dermatology as well as articles by other authors working in this field. There are 40 contributors, and as is usually true with books of multiple authorship, there is considerable unevenness of quality and emphasis in the various articles.

Approximately half of the book discusses a wide variety of both superficial and systemic mycoses. The remainder rather briefly covers pathology, therapy, immunology and diagnosis of these diseases. There are a number of typographical errors in the text and in the index.

Because of its nature, this book is not suitable to be recommended as a text for students. However, experienced dermatologists and mycologists will likely find many items of value in it. *Harris D. Riley, Jr., MD*

GYNECOLOGY, Edmund R. Novak, Georgeanna Seegar Jones and Howard W. Jones. Ninth Edition: cloth. Baltimore: The Williams and Wilkins Company, Inc., 1975. Pp. 452.

This 452 page paperback is condensed from the ninth edition of Novak's Textbook of Gynecology. The authors state in the preface that with the eighth edition a paperback edition which selectively was a reduction in size and designed specifically for students, was printed. This proved to be popular and the present edition is an update of that. The ninth edition contains significant revisions in the sections on endocrinology, cytogenetics, oncology and population control.

This book will be useful to students but persons who have made a career choice to specialize in the field of gynecology will, of course, need a more comprehensive textbook. *Harris D. Riley, Jr., MD*

PAEDIATRIC INTENSIVE CARE. By Keith D. Edwards and Jennifer M. Edwards, Pp. 271. Blackwell Scientific Publications, Oxford, England, 1971.

This small book is based in part on lectures given during the "Intensive Therapy Course" of the United Birmingham Hospitals. Because it is written for both senior nurses and junior medical staff, it sometimes lacks balance in the amount of detail given. There are good sections on fluid and electrolyte problems and methods for monitoring patients. There is a brief chapter on special care of the neonate.

This book will be of value to house officers and nurses concerned with intensive care of children. *Harris D. Riley, Jr., MD*

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS Louis S. Goodman and Alfred Gilman Fifth Edition. MacMillan Publishing Co., Inc., 1975. Pp. 1704.

This book remains one of the most important medical publications of our time. It is a prime reference source for all therapeutic problems involving drugs. The fifth edition like its predecessors retains the same excellent organization, clarity of writing and authority. Two associate editors, Alfred G. Gilman and George B. Koelle have been added. This edition discusses fully both newly approved drugs as well as those that are still in the development stage but show considerable promise as future therapeutic agents.

Every physician should own this book. *Harris D. Riley, Jr., MD* □

32nd Annual Meeting

"Forum For Medical Affairs"

Sunday, June 27th, 1976 Dallas, Texas
Fairmont Hotel

This half-day meeting is sponsored by the Conference of Presidents and Officers of state medical associations. Topic for the meeting will be "Federal Bureaucracy and Regulation — Impact Upon the Physician and His Patients." Guest speakers will be Doctor Harry P. Cain, acting director of the Bureau of Health Planning and Resource Development, H.E.W., Washington; the Honorable Jim Wright, Congressman, 12th District Texas Member, Committees on Budget, Government Operations, Public Works and Transportation; and, Irvine H. Page, MD, Editor, *Modern Medicine.*



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OSMA JOURNAL / *the last word*

An ongoing education/public relations tool for Oklahoma physicians will soon be ready for distribution, says M. Joe Crosthwait, MD, Chairman of the OSMA Council on Public Policy. Doctor Crosthwait displayed a number of the educational placards during the OSMA annual meeting. According to Doctor Crosthwait, the placards will be placed in every physician's office in the state. The placards are designed after the masthead of a newspaper and are called "Medical Update." Each contains three pockets and will be inserted with informational fliers on current medical issues. According to Doctor Crosthwait, these fliers will be constantly reviewed and changed in order to insure their timeliness. He said they should be ready for distribution early in the summer. The Midwest City physician who was recently elected OSMA Vice-President, explained this is part of an overall effort to increase and improve the medical profession's public image in Oklahoma. (An interview with Doctor Crosthwait about the Council and his concept of public relations is in this Journal).

After more than two months at the Legislature and after more than two years in the planning stages, SB 622 has passed its legislative review and has been signed by the governor. It is now an Oklahoma law which promises to give Oklahoma doctors some much needed relief from their ever increasing malpractice problems. The final tally on the bill was 42-1 in the Senate and 88-3 in the House. (A review of the bill in its final form was featured in the April issue of OSMA News. Another report can be found in this *Journal*).

The Federal Trade Commission is up to old tricks again. Only this time it will investigate the AMA to see if it "may have illegally restrained the supply of physicians and health care services." According to the AMA, the FTC's probe this time will cover "accreditation of medical schools and allied health personnel; and limitations on forms of health care delivery inconsistent with a traditional fee-for-service approach." In a public release, James H. Sammons, MD, Executive Vice-President of the AMA said he welcomed an airing of the issue. According to Doctor Sammons, the number of medical schools has risen 30 percent during the past ten years. Doctor Sammons also said the number of physicians has risen 30 per cent and the number of first year medical students has increased by 69 per cent. He said ten years ago there was one physician for every 682 Americans compared to one for every 569 Americans today.

Again with the FTC, it appears that if that federal group has its way, both doctors and dentists will soon be looking for a good advertising firm. The FTC has informed the American Dental Association that it will investigate the code of ethics for dentists to determine whether it is in violation of the Federal Trade Commission Act. The FTC apparently cited the same section of the act under which it decided to launch an investigation of the AMA. The FTC asked the ADA to supply information by April 30. The ADA has, however, asked for an extension to May 31st.

Lawsuits contesting the constitutionality of the Health Planning and Development Act have been filed by the State of North Carolina and the National Association of Regional Councils, says a report in the May 3rd issue of "AMA Newsletter." The AMA also plans to join North Carolina in the lawsuit and is expected to file a petition to intervene soon.

The North Carolina lawsuit, filed in late April, charges that the planning law would force that state to violate its own constitution or lose its federal health funds. The lawsuit further charges that the new law requires the passage of certificate-of-need legislation which has already been declared unconstitutional by the North Carolina Supreme Court.

The NARC suit charges that the health planning law is an illegal intrusion by the federal government on the rights of state and local governments. The NARC is a Washington-based organization of local government councils. □

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(Cover Art By William Cason)


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Is Postoperative X-ray Therapy Warranted in Primary Breast Cancer?

In studying the many tumor board recommendations from The Oklahoma Hospital Breast Cancer Control Network one fact stands out which became evident from reviewing the primarily operable cases with lymph node involvement. Radiotherapy as an adjunct to breast surgery has gained wide acceptance throughout this state. Twenty-three such cases were discussed and radiotherapy was advised in 19 of these. L-Pam was also suggested in many of these cases in addition to x-ray therapy.

The result of Fisher and Bonadonna (plus many others) has recently cast much doubt on the value of adjuvant radiotherapy. At the same time many preliminary studies have shown the value of surgery plus chemotherapy either with a combination of drugs or a single agent. The survival rates are significantly improved and it appears that a real breakthrough is imminent with the addition of chemotherapy to surgery.

Stjernsward found a decreased survival of one to ten percent in a group of mastectomy patients who received postoperative x-ray. This is compared to a similar group who had operation alone. Radiotherapy prevented local recurrence but increased distant recurrences leading to earlier systemic disease.

Radiotherapy is immunosuppressive as is chemotherapy. However the drugs are pulsed and the immune system allowed to recover between courses of the drug. Some patients receiving irradiation have a long-lasting lymphopenia. This has been suggested as one reason for decreased survival and an increase in distant metastases. Many feel that one of the effects of irradiation is to permanently impair the immune system.

The regimen of surgery plus adjuvant chemotherapy assumes that there are distant micrometastases particularly in those patients with lymph node involvement. In order for chemotherapy to be effective in eliminating the minute foci the immune response must be preserved.

The entire therapy of breast cancer is on the threshold of revision. The extent of surgery may have to be changed in view of the advances in chemotherapy and immunotherapy.

At the present time the National Study Adjuvant Breast Project is conducting a prospective study of surgery-plus-chemotherapy with half the group receiving radiotherapy in addition. This should help answer the question as to whether radiotherapy is warranted as adjunctive therapy in breast cancer.

JOE M. PARKER, MD

EDITORS NOTE: This timely editorial by Dr. Parker focuses appropriate attention on a most controversial subject. It is published with the hope that drastic changes will be forthcoming in our current (and provincial?) treatment of patients with cancer of the breast. MRJ



In April, the OSMA House of Delegates found itself positioned as a "house in a dilemma," facing a difficult decision concerning voluntary AMA membership as opposed to required membership. The decision it finally reached was one of compromise — which now faces a serious constitutional question. The matter must now be resolved by the Board of Trustees — acting as the Judicial Council of the OSMA.

For at least the past three or four years, one of the most controversial issues which has come before the house has been the question of voluntary versus required AMA membership. Until 1976, proponents of unified membership have been in the majority, and Oklahoma has consistently remained a unified state. This year, however, the division on the question was closer than ever before, and the final decision made by the house may not withstand a constitutional examination; according to the decision of the house, OSMA members are no longer required to belong to the AMA, but payment of the $250 AMA dues is still required nonetheless. If an Oklahoma doctor wishes to belong to the state association but not to the national, then the $250 will be "equitably" divided between the county medical society and the OSMA, according to a formula to be determined by the Board of Trustees.

The board is made up of fair and prudent physicians, and their decision on this constitutional question will be as fair as any judgment involving controversies can be. I don't know what the final decision will be, but I have confidence in whatever act they take because I know they are men who express themselves freely and responsibly and who will not be stampeded into any rash action. I do, however, want to make my own feelings on the issue clear.

I strongly believe that we should *all* be active members of the AMA. Our Oklahoma State Medical Association *requires* that all members of OSMA also be members of the local constituent medical society — *that's required.* All members must be citizens of the USA—*that's required.* All members must also be licensed to practice medicine in Oklahoma — *that's required.* Most hospital medical staffs also have many requirements. It seems to me that the issue isn't really required versus voluntary AMA membership.

Any licensed physician in Oklahoma can practice medicine whether or not he belongs to any medical organization, and from 250 to 300 physicians have chosen not to join organized medicine in this state. The real issue is *shall members of organized medicine in this state be members of all component organizations.* That's the choice each physician must make.

So in reality every physician in Oklahoma does have a choice — a choice of whether or not he will be a part of organized medicine — county, state, and national. It's his choice and its voluntary.

Our association worked very hard to secure passage of the malpractice reform bill, SB 622. The beneficiaries of this malpractice legislation are not only members of the OSMA; nonmembers, osteopathic physicians, and hospitals benefit equally. Our patients also benefit from this bill.

In the same way, physicians who do not belong to the AMA benefit from its vast efforts, efforts which include direct challenges to unfair and imprudent governmental intervention. The AMA needs all of us as members in order to carry out its important functions, but more importantly, we need the AMA as our national representative. Think about it. Being a member of organized medicine is voluntary now, the way it has been in Oklahoma for 26 years. The real choice is whether or not we will be part of the total team.

I repeat, these are my own personal feelings. The Board of Trustees and the House of Delegates may see it differently, and their decision will be my guideline because I am a member of the team. I am a part of organized medicine — local, state, and national.



Historical Perspective in Cardiology: The Tetralogy of Fallot

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Since the first notation of Tetralogy of Fallot (1671) advances in description and treatment of this defect have been made by the pioneers in pediatric cardiology.

The Tetralogy of Fallot is the most common form of cyanotic congenital heart disease and constitutes approximately five to ten percent of infants and children with congenital defects.[1] The "Tetralogy" consists of (1) infundibular pulmonic stenosis, (2) ventricular septal defect, (3) dextroposition or overriding aorta and (4) right ventricular hypertrophy.[1]

Infants and children with this lesion are cyanotic and most, without surgical intervention, experience severe incapacition and death. There is a spectrum of disease, however, ranging from the acyanotic child to the newborn with severe cyanosis.[2]

The first description of the Tetralogy of Fallot was by Niels Stensen in 1671.[3,4] Stensen,[5] born in 1638 in Copenhagen, Denmark, entered the University of Copenhagen at age 18 years where his advisor was Bartholin; he then went to Amsterdam and studied with Blasius. It was here that he described the secretory duct of the parotid (Stensen's duct). His studies continued at the University of Leyden with Van Hoorne and Sylvius. Stensen investigated the glands of the eye, vessels of the nose, the brain, the heart (describing it as composed chiefly of muscle fibers), and areas of geology. In his later years, Stensen became a priest; he died in 1686. Stensen's description of Tetralogy was from a heart protruding through the sternum of a fetus.[3] A number of other authors[2,4] subsequently described the anomaly. Some of these we shall examine in detail.

In 1777, Sandifort, who had thought that his patient had acquired disease, at postmortem recorded:[6,7]

> So imagine our surprise when we found the heart to be grossly malformed and that the aorta arose in part from the right ventricle . . . a condition which must have been present from birth.

His patient was a 12½-year-old boy who had great difficulty breathing, palpitations and cyanosis since one year of age. The postmortem specimen showed that only a small probe would pass the pulmonary outflow. The foramen ovale was also patent.[8]

In 1783, Hunter reported a case[7,8] of a child who died in 1761, early in its second decade,

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who was always cyanotic and had "paroxysms of difficulty in breathing but could arrest them by lying on the carpet when they were coming on." This was clearly an account of a "spell." Peacock[8] describes the postmortem finding:

> On examination, the orifice of the pulmonary artery was found very greatly contracted and the septum of the ventricle was imperfect, as in the case of Sandifort; but the foramen ovale, though not expressly mentioned, may be inferred to have been closed.

In 1785, Pulteney published a case he had seen in 1781.[8] This boy died at 13 9/12 years of age with "dysentery" but had cyanosis, dyspnea and fatigability. His heart at postmortem was just as described by Sandifort and Hunter. He noted that a "finger could be passed from the aorta into either ventricle."

In 1793, Abernathy[8] described the same malformations in a boy who died at two years of age. Two years later, Duncan described the malformation in a boy who died at 10 months of age and many other reports soon followed.[8]

In 1812, Jean Nicolas Corvisart recorded in detail in his *Essay on the Organic Diseases and Lesions of the Heart and Great Vessels* prepared from his clinical lectures a case of what was to be Tetralogy.[9]

> Case XLVII — A child, aged twelve years and six months, April 22d, 1797, was admitted into the Clinical Hospital. He was then in so alarming a condition that it was to be feared that his dissolution was near. The complaint with which he was troubled, according to his opinion, took place only five months before; but from the violent and repeated palpitations which he had always suffered, it might be readily decided that the heart had been much longer affected with this organic lesion.
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> When he was received into the hospital, his countenance was bloated, his lips were purple, and extremities without the appearance of infiltration. Respiration was particularly embarrassed; the hand laid over the region of the heart felt quite an irregular stroke, attended with a peculiar very remarkable rushing; nevertheless the pulse was of surprising regularity, but small, feeble, and easy to suffocate. Palpitations were frequent and returned by fits, accompanied with a threatening suffocation.
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> The patient could not rest horizontally, but found himself more relieved when sitting, and still more, bent forward. His urine was passed often and profusely. During his short tarry in the hospital, the disease made frightful progress. He used diuretics, and very powerful anti-spasmodics; but the employment of these means procured, as it was anticipated, no relief.
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> April 25th, he had a more severe paroxysm of suffocation than he had previously experienced, and which appeared must terminate his life; but it ceased, and he, immediately after, became sensibly better than he had been for a long time. The more alarming symptoms soon returned; and the child, admitted April 22d, died the 26th of the same month, after agonies of ten or twelve hours, during which his whole body was covered with a cold sweat, and a yellowish froth flowed from his mouth.
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> On dissection of the thorax, the lungs appeared natural; they were, however, somewhat tender.
>
> The pericardium contained a small quantity of fluid. The heart was consideraly enlarged, and appeared much rather to belong to a tall man of a vigorous constitution, than to a subject so young. The auricles of the heart presented nothing remarkable but their enlargement.
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> The parietes of the right ventricle were more thickened than they usually are. The partition of the ventricles had preserved its natural thickness; the same partition, at the origin of the pulmonary artery, was perforated with a round aperture capable of admitting the extremity of the little finger. The aperture communicated directly with the cavity of the left ventricle; its edges were smooth and whitish in their whole extent. At the upper part of the circumference of the foramen, were seen two little fleshy tubercles of a reddish color.
>
> The parietes of the left ventricle had preserved their natural thickness. In the cavity of this ventricle, directly below one of the sigmoid valves of the aorta was observed the left aperture of the foramen of which I have spoken.
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> The aortic semi-lunar valve below which it was found situated, was corroded and partly destroyed. It formed a sort of little fringe which appeared at the orifice of communication, without stopping it entirely; so that the blood, propelled by the left ventricle into the cavity of the aorta, could, when this ventricle

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ceased to act, regurgitate on account of the destruction of the sigmoid valve, into the right ventricle, by passing through the preternatural aperture, whose direction seemed however to be from the right ventricle toward the cavity of the left.

An important question which, from the details of the case, and from the inspection of the body, appears to me still undecided, is to know whether the aperture, described, existed in the subject from his birth? Then it would be an actual malformation, or whether it was accidentally formed by rupture, or erosion; in the latter case, it must be ranked among organic disease? The smooth and apparently tendinous state of the edges of the aperture would seem to favor the first opinion; on the other hand, the erosion of one of the semi-lunar valves which surrounded the aperture, the existence of the tubercles, etc., would seem to support the second.

The perforation of the partition of the ventricles has some analogy with the existence of the foramen ovale, in a man already advanced in years. The modifications which these different morbid states produce in the circulation, appear to approach so nearly that I shall not be able to consider the effects of each of these preternatural states till I have exemplified the last affection in question.

Later, Corvisart discusses this malformation. Under the title "A preternatural state in which the aorta arises from both ventricles."

I gave, in the preceding paragraphs, the description of several pathological states of the heart, the more surprising as they seem to subvert entirely the natural order of the circulation. To render the picture of these sports of nature more complete, which appear to destroy every physiological opinion, I deem it necessary to treat briefly of a case related by Sandifort, in his work entitled, *Observations anatomico-pathologiques.*

A child, having enjoyed good health during the first year of its life, was in the beginning of the second, attacked with all the symptoms which characterize the most alarming disease of the organ of circulation. This affection, which would be too long to detail here, became, for the twelve years that the patient lived, more and more dangerous. After this interval, it fell a victim to a disease which, from its nature, seemed that it must have taken place much sooner.

On dissection, it was observed, beside the existence of the foramen ovale and dilatation of the right ventricle, that the aorta, instead of rising from the left ventricle only, had a mouth in each of the ventricles.

A case, very similar to the preceding, was seen by Steno, and related by Th. Bartholin, in the acts of Copenhagen; but his subject was an embryo that exhibited too great a malconformation, to be precluded from the rank of monsters.

The two cases, quoted above, from M. Dupuytren and Beauchene, the son, presented a similar malconformation.

I shall not try to explain the astonishing modifications which the circulation must have undergone in the preceding case; I have enlarged sufficiently upon the singular derangement which must follow from these different morbid states. I will let the physiologist decide how far established laws of the circulation, and especially the theory which now serves to explain the influence of respiration on the renovation of the blood.

Corvisart was born in the village of Doricourt and came to Paris to study law but soon turned to medicine. He received his degree in 1785, and became a professor of medicine in the college de France in 1797 and in 1804 he became Napoleon's physician. Corvisart lived from 1755 until 1821.

Peacock, a physician at St. Thomas' Hospital, London, in 1866 described in detail cases of "Tetralogy" in his classic text *On Malformations of the Human Heart*[8] and presented a drawing of this malformation from one of the cases he presented. This was the heart of a 2 5/12-year-old child from the Museum of the Victoria Park Hospital. (Figure 1) He classifies



Fig. 1.

this abnormality as "Defect in the interventricular septum; aorta arising in part from the right ventricle; obstruction at the pulmonary orifice." He describes the anatomic defect:

> When the septum deviates to the left, so that the aorta acquires a communication with the right ventricle, there is most generally some source of obstruction at or near the origin, or in the course, of the pulmonary artery.
>
> Generally, in cases of this description, the number of the pulmonic valves is defective, and they are otherwise diseased; but there may be constriction of the orifice itself, or of the pulmonary artery. When the number of the valves is defective, there may be only two segments; or the orifice may be imperfectly closed by a membrane stretched across and perforated in the centre; or the valvular apparatus may be still more imperfect, being only represented by a duplicature of the lining membrane, or by a band of muscular fibres surrounding the orifice.
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> When only two valves exist, one of the curtains is generally much larger than the other, and presents evidences that it originally consisted of two distinct segments, which have become united together; the former line of separation being indicated by a ridge or frenum, extending from the edge of the valve to the side of the artery. When the valvular apparatus has the form of a perforated membrane, or, as it has been termed, of a diaphragm, the three segments are united together, and there are three ridges or frena, on the upper side, with corresponding sulci or furrows, on the ventricular side.
>
> Whatever be the form of the valvular apparatus, the curtains are generally protruded forwards in the course of the artery; so as to give the opening from the ventricle a funnel shape, and to form deep sinuses between the valves and the sides of the vessel. The orifice itself varies in shape according to the number of segments. When there are two distinct valves, it is generally in the form of a slit, extending from side to side: when on the contrary, there is only a perforated membrane, the opening is usually triangular or rounded. In some cases the bases, as well as the free edges of the valves, are contracted, and the orifice has a tubular or barrel shape. Occasionally the constriction is not caused by disease of the valves, but is situated at the outlet of the ventricle; and depends on disease of the fibrous zone to which the valves are attached, or on hypertrophy of the adjacent muscular substance and thickening of the endocardium. Obstruction may also be caused by general smallness of the pulmonary artery; and by rigidity of the orifice which prevents its expanding duly with the progress of growth.
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> The size of the orifice varies greatly in different cases. It may admit the point of one of the fingers, or a lead pencil, or common quill; or it may only allow of the passage of a crow-quill or probe. M. Louis has recorded a case in which, in a man twenty-five years of age, it measured only two and a half lines in diameter; and M. Bertin found the aperture to have the same size in a female of fifty-seven. I have myself measured the capacity of the orifice in two males, fifteen and twenty years, and in a female nineteen years of age, and found the circumference thirteen, twelve, and eight French lines respectively: — the average size in adults being about thirty-six French lines. In two children, six and a half and two and a half years of age, the circumference of the orifice was six and a half and five French lines.
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> In most cases the valves are not only adherent but they are otherwise much diseased, being thickened, irregular, and indurated; and, if life be sufficiently prolonged, not unfrequently contain larger or smaller masses of cretaceous deposit. From the similarity of these changes to those which result from inflammation in after life, they may be referred to that process occurring during fetal existence. Generally, also, the valves become the seat of subsequent disease and display recent deposits or vegetations by which the contracted opening is often still further diminished in size. In most cases, at least when all the segments are united together, the valves are incapable of entirely closing the aperture.
>
> The trunk of the pulmonary artery is in some cases dilated, in others it is smaller than usual; and its coats may either be thickened and indurated, or they may be thin and transparent, more resembling those of veins.
>
> In most cases of this description of malformation, the foramen ovale does not become entirely closed; but such is not always the case, the septum of the auricle being in some instances entirely imperforate; while in others the foramen ovale may close naturally, but an apertuture may exist in some other portion of the auricular partition. The ductus arteriosus occasionally remains pervious; and the tricuspid valves are frequently diseased, the folds being adherent at their edges, and their surfaces studded with fibrinous deposits or vegetations.
>
> With an imperfectly divided ventricle, the heart may possess its natural form externally, and the defect may only be detected on laying open the cavity; but more generally, and especially when the septal defect is considerable, the organ is wider than usual, resembling the quadrangular form of the heart of the turtle. This change is more marked when, with deficiency in the inter-ventricular septum, there is some obstruction to the exit of the blood from the right ventricle, by the pulmonary artery. The infundibular portion of the right ventricle is then usually imperfectly developed, its cavity very small and the walls hypertrophied; while the sinus is much en-

larged, its parietes acquire a greatly increased width and are peculiarly tense and resisting, and the muscular columns become much hypertrophied. In a boy of ten, and a girl of nineteen years of age, the walls of the right ventricle measured 5 and 5½ French lines in thickness; — the average width in adults, of the two sexes, being 1.93 and 1.87 French lines. The right auricle undergoes great dilatation, and its parietes become unusually thick. The left cavities on the contrary are, relatively, much smaller, and their walls thinner and more flaccid.

While, however, the chief valvular disease, and the most marked hypertrophy and dilatation, are found in the right cavities of the heart, the changes are not entirely limited to that side, but affect, to a less degree, the left also. Thus the folds of the mitral valve are not infrequently found opaque and thickened, and the aortic valves may be in a similar condition, or the number of the curtains may be irregular. The hypertrophy and dilatation of the left ventricle are most marked in persons who survive for some years; and, in such cases, the general enlargement of the heart and the increase of weight which it attains, are often considerable. In the two patients before referred to, the organ weighed 10 oz. and 17½ oz. avoirdupois respectively, though the normal weight, at the same ages, should not exceed eight or eight and a half ounces.

Some discussion has arisen as to the cause to which the hypertrophy of the right ventricle in cases of malformation is to be ascribed; and it has been supposed by Bertin, Bouilland, and others, to be due to the entrance of aerated blood, through the aperture in the septum. This explanation cannot, however, be accepted as satisfactory. When there exists any source of obstruction at the right side of the heart, as in by far the majority of instances in which the septum is imperfect, the course of the blood through the aperture will be from the right ventricle into the left; and it is probably only in the comparatively small proportion of cases, in which, with a defective septum, there is no source of obstruction on the right side, that the reverse obtains. In the latter class of cases, however, the right ventricle does not become hypertrophied to any great extent, though the patient may survive for many years. But, whenever there exists any source of obstruction at or near the pulmonic orifice, and whenever the deficiency in the septum is so great as to throw upon the right ventricle a large share in the maintenance of the systemic circulation, the right ventricle is invariably found more or less hypertrophied; even though the life of the patient may be prolonged only for a few weeks or months. The ventricular parietes also acquire as great an increase in width and firmness, in the cases in which there is obstruction at or near the pulmonic orifice without any defect in the interventricular septum, and therefore without any entrance of aerated blood, as when the partition is imperfect. It seems therefore evident, that the hypertrophy of the right ventricle in these cases, is due to causes precisely similar to those which occasion hypertrophy of either ventricle in after life; — the increased growth which is consequent on the powerful muscular efforts to overcome the obstruction occasioned by the contracted or rigid state of the pulmonic orifice, or to maintain the circulation in the systemic, as well as in the pulmonic vessels.

In speaking of imperfection in the interventricular septum, it has been mentioned that the defect may exist in very different degrees. The extent to which the septum may be misplaced may also vary greatly. In some cases only a small portion of the aortic orifice, as one-third or one-fourth of its circumference, is in connection with the right ventricle. In others, the aorta is placed immediately above the incomplete septum, so as to communicate equally with both ventricles; and, in yet other instances, it arises wholly from the right ventricle.

He then recorded in detail cases of this malformation which had come to his attention.

It was not until 1888 that Etienne-Louis Arthur Fallot described the lesion that was to bear his name even though it had clearly been described before. Fallot[5] was born in Cette, France in 1850 and studied medicine at the Ecole de Medicine at Marseille and worked at the University of Marseille for the rest of his life. He died in 1911. In 1888, the year he was appointed Professor of Hygiene and Legal Medicine, he wrote:[10]

> Until now, clinicians have considered the precise diagnosis of anatomic lesions of morbus caeruleus of almost unsurmountable difficulty, . . . We see from our observations that cyanosis, especially in the adult, is the result of a small number of cardiac malformations well determined.
>
> One of these cardiac malformations is much more frequent than the others, since we have found it in about 74 percent of our cases; this is what the clinician should diagnose and in doing so, his chances of error are relatively slight.
>
> This malformation consists of a true anatomopathologic type represented by the following Tetralogy: (1) stenosis of the pulmonary artery; (2) interventricular communication; (3) deviation of the origin of the aorta to the right; (4) hypertrophy, almost always concentric, of the right ventricle.

Thus, we have the first description of the Tetralogy of Fallot. He continued: "Failure of obliteration of the foramen ovale may occasionally be added in a wholly accessory manner." This has been labeled the Pentalogy of Fallot.

The idea that this malformation was a single

defect was proposed even in 1888. Fallot concluded:

> It seems to be much more logical and more in conformity with the laws of physiology to regard the whole series of cardiac changes enumerated as wholly the result of pulmonary stenosis. As to the cause of this, we believe that we must attribute it not to a simple arresting of development but rather to a pathologic process developing during intrauterine life at the level of the pulmonary valves and of the region of the infundibulum which is contiguous to them.

In the course of 13 years, Fallot studied at postmortem three hearts that displayed his Tetralogy; the patients died at ages 19, 26, and 36 years; the latter patient was diagnosed clinically by Fallot and died with endocarditis of the aortic valve. He also reviewed the literature and isolated 19 cases collected by Debely in 1878 and 39 others from 1878 to 1888 that had this combination of lesions.

In the years prior to the description by Fallot, texts of the day contained very little about this malformation.

Hayden, in 1875,[12] discussed the causes of heart disease. These were of three types — 1) hemic (in this he includes rheumatism, scurvy, and syphilis); 2) mechanical (in which are included blows upon the chest, malformations or deformities of the chest with pressure upon the heart); and 3) nutritive (including structural degeneration secondary to malnutritive (including structural degeneration secondary to malnutrition). That published by Russel in 1886[13] contained nothing on cardiac disease in childhood, and in 1887, one year before Fallot described the Tetralogy, Professor Dujardin-Beaumetz[14] had almost no information on such lesions but did have a note relating the state of medicine of these lesions at that time:

> In fact, we are generally in the presence of a chronic disease, incurable in its nature and recognized as such.

Even after Dr. Fallot's writing, little of note reached available textbooks.

In 1892 Sansom[15] described a clinical evaluation of lesions in childhood and differentiated between those with or without pulmonic stenosis although there was no specific mention of Tetralogy of Fallot.

> In infancy the patient will probably be the subject of cyanosis, presenting the characteristics which we have already considered. It may be that the murmur is heard loudly at the base of the heart, though in the small area of chest presented in infancy, the observer may not be able, possibly, to locate it in the pulmonary region. The blueness of surface, however, the venous distension, and the extreme improbability of aortic disease at this period of life will leave little doubt as to the diagnosis. It may be generally inferred that a patent foramen ovale or an aperture in the interventricular septum to exist with the pulmonary obstruction.

Broadbent, in 1898[16] and in 1900[17] clinically describes this child.

> The child suffering from a serious congenital affection of the heart is usually irritable and fretful, and may be subject to fits. The fingers and toes are clubbed and the extremities cold. He may be always cyanosed on exertion. There will usually be constant shortness of breath and paroxysms of dyspnea may occur, in which cyanosis becomes so intense that the extremities become almost black.
>
> He will remain stunted in growth and backward in development, intellectually as well as physically.
>
> Where with pulmonary stenosis the interventricular septum is also deficient, the prognosis is much less favorable, for not only must the pulmonary constriction be considerable to have given rise to this deficiency, but, further, in such cases the aorta usually arises in part from the right ventricle. Of sixty-four such cases collected by Peacock, only 14 survived the age of 15. If, however, the degree of pulmonary stenosis is slight and the perforation in the septum small, life may be prolonged, and two patients are now living at the age of 30 or upwards in which I believe this condition to exist; one has borne a child.

Hatfield[18] in 1903 in *A Compend of Diseases of Children* describes patient with cyanotic heart disease. He calls the disease cyanosis with synonyms Morbus Ceruleus and the Blue Disease.

> Strictly speaking, not a disease at all, but an almost invariable symptom of any disease attended with defective oxygenation of the blood. Of special importance in early life as indicating cardiac malformation, though it should be remembered that this may exist without cyanosis. "White Cyanosis" is the name given by Mouls to such cases. Morbus Winckelii is the name given to an epidemic form of cyanosis first fully described by Winckel in 1879, as observed by him in the Dresden Hospital. Some sporadic cases had previously been reported by Garrod, Begelow and Baginsky.
>
> Once supposed to be due to malevolent spirits. In more than half of the cases, examined after death, malformations have been found in the pulmonary artery. Others arise from the mixing of arterial and venous blood in the heart, from a patent foramen ovale or

other congenital defect; and others, according to J. Lewis Smith, are due to a congenital failure of oxygenation of the blood without recognizable lesions. No accurate chemical examination of the blood of cyanotic children has yet been made, but it probably closely resembles ordinary venous blood. The liver is usually large and congested; pericardial and pleuritic effusions are frequent occurrences. More frequent with males than females and increases with bulk of population. Often hereditary in families, but even when due to congenital malformation, symptoms not necessarily occur immediately after birth.

Symptoms are chiefly those of blueness or lividity of the face, lips, and tips of the fingers, intensified by exertion or fright, which occasion paroxysms of dyspnea. Clubbing of the fingertips found in all chronic cases. Prognosis — unfavorable for recovery, though not immediately fatal, for life may be prolonged for years. Eighty percent die in the first five years. Very bad in Winckel's Disease.

Treatment — Rest, mental and physical, digitalis, quebrache and chlorate of potash and tonics.

That same year, Babcock[19] in his *Disease of the Heart and Arterial System* had no real mention of this entity. Likewise, in 1910,[20] James MacKenzie allowed two pages for all of congenital heart diseases and does not mention Tetralogy.

In 1910, Hirschfelder[21] of the Johns Hopkins University, devoted almost 40 pages to congenital heart disease. His descriptions of children and young adults with "pulmonary stenosis with patent interventricular septum" were as follows:

> So striking and so frequent is the occurrence of intense cyanosis in congenital heart disease that this term has become almost synonymous with the morbus coeruleus (blue sickness) described by Senac.

He described vascular changes in the retina as "tortuous veins resembling large angleworms," and noted the "clubbed or Hippocratic fingers, a rough systolic thrill, and the murmur of pulmonic stenosis." He includes a comment on treatment and prognosis:

> The general cardiac stimulants, such as digitalis and strychnine, are rarely of much value, since in most cases the heart has already reached the maximum of its power and cannot be stimulated much further. Rate of dilatation from amyl nitrite and nitroglycerin may sometimes help, and Peacock recommends the use of warm baths or mustard baths especially for the convulsions of children.
>
> Of Stolelker's fifty-three cases, thirty-two died at birth, twelve during the first year, eleven during the first decade. Only four reached the fourth decade.

His description of cyanosis of Tetralogy, although not called by that name is striking:

> It may then come in attacks associated with dyspnea, sometimes convulsions. The patients may become quite black in the face and remain so for some time.

In 1914, Sutherland[22] in *The Heart in Early Life,* gave little emphasis to congenital heart diseases or cyanotic disease.

Even in 1929, in the text of Garrod,[23] Cyanosis or Morbus Coeruleus was mentioned in general terms only with no hint to the pediatrician on how to diagnose this malady.

> There will remain a large class of patients who are hopelessly crippled from the start owing to defective circulation. They require careful nursing, careful feeding, fresh air and sunshine and protection as far as may be from acute infectious and other forms of intercurrent disease.

Also, in 1929[11], Paul Dudley White and H. B. Sprague reported the oldest known patient with Tetralogy and brought further attention to this lesion. The patient was Henry F. Gilbert, the noted American composer, who had been examined by Dr. White and diagnosed as having Tetralogy. When he died at age 60 years, postmortem study confirmed the clinical impression. Since no treatment was available, this report was presented primarily to offer encouragement that longevity and a useful life were possible.

In 1931, Dr. White[24] discussed Tetralogy and translated Fallot's original thoughts. He noted that this was the most common cyanotic congenital lesion in adults and his estimate was that it constituted 2% of organic disease in New England and 5% of cases of organic heart disease in children.

Shortly after this, in 1936, Maude Abbott published her *Atlas of Congenital Cardiac Disease*[25] and described in detail the Tetralogy of Fallot. In an average of 83 cases, the maximum age noted was 25 years with the average 12¾ years. This excluded a few of very unusual age. She described carefully the physical and laboratory findings of children with this lesion.

More recently, the clinical descriptions of the Tetralogy of Fallot[1,7] make it a clearly recognizable cardiac anomaly.

The anatomic description of Tetralogy has been restudied over the years. Spitzer felt erroneously that it was a form of transposition and called it "Type I Transposition.[26]" Maude Abbott [25] reviewed both clinical and pathologic findings; Edwards[27] and Lev [28,29] contributed anatomic details.

The anatomical abnormality of Tetralogy has also been examined in more detail by Van Praagh[31] who feels that it is a monology — underdevelopment of the pulmonary infundibulum and all four characteristics of Tetralogy are secondary to this[30]. This is all part of a general scheme of developmental pathologic concepts[31, 32] which makes a coherent story to congenital heart disease.

The surgical intervention in this lesion did not come until 1944. Dr. Helen Taussig[33, 34] had been in charge of the Children's cardiac clinic for a decade-and-a-half at The Johns Hopkins Hospital. With the encouragement of Dr. Edward Park, department chairman, she became interested in infants and children with congenital defects. Along with the physical examination, the chest x-ray, electrocardiogram and fluoroscopy allowed her to identify a number of patients with Tetralogy of Fallot. She felt that the construction of an artificial ductus might be beneficial to these children. In later reflections[34] Dr. Taussig recalled stating on numerous occasions: "This child would be helped if we could only build a ductus." At that time, Dr. Robert E. Gross of Boston was the established pioneer in pediatric surgery and cardiac surgery for congenital heart disease. Dr. Taussig met with Dr. Gross but did not convince him to try this in children although he had created an "artificial ductus" in experimental animals. Dr. Taussig convinced Dr. Alfred Blalock, Surgeon in Chief at the Johns Hopkins Hospital, to create a systemic-artery-to-pulmonary-artery shunt in animals. Blalock had already anastomosed the proximal end of the left subclavian artery to the distal end of the left pulmonary artery and he then perfected an end-to-side anastomosis and reduced cyanosis in dogs.[35] Despite many misgivings, on November 29, 1944, Dr. Blalock performed[36] an end to side anastomosis of the left subclavian artery to the left pulmonary artery in a 15-month-old little girl with Tetralogy. The operation was long and tedious and the post-operative course was difficult but improvement occurred. However, six months later a second shunt was necessary and she died five days later. The next patient was not operated upon until February 3, 1945 and was an 11-year-old girl with Tetralogy of Fallot. This time Dr. Blalock constructed an end-to-side innominate artery-to-left pulmonary artery anastomosis. There were many other children and operations, the majority having Tetralogy. Dr. Taussig spent many years reviewing all these cases to evaluate what had happened to them. Unfortunately, a number of long-term complications were noted although most children had enjoyed tremendous gains, thanks to this therapy.[37, 38]

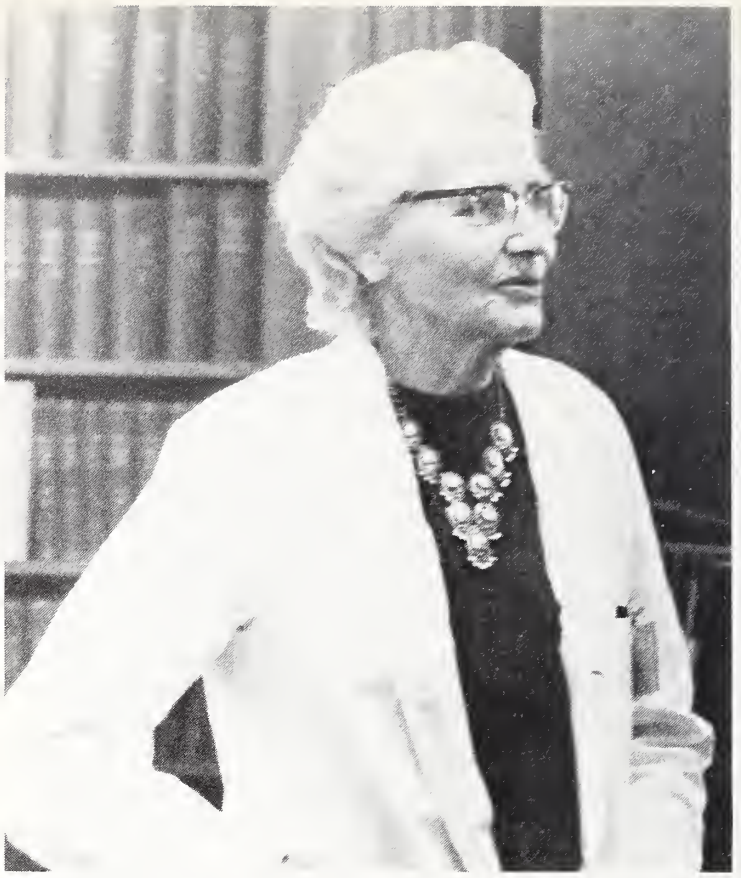


Fig 2
Helen Taussig. (Reproduced by permission of Robert Levy, MD. Photo taken in April, 1973.)

Next, at the Children's Memorial Hospital in Chicago, Willis J. Potts created an anastomosis[39] between the descending aorta and pulmonary artery of a young girl with Tetralogy. This operation was performed on September 13, 1946, and has been described in detail.[40] In many children the operation devised by Drs. Blalock and Taussig was not feasible due to anatomic restrictions and the Potts operation was used. Just as in the former, the Potts operation was widely used and for lesions other than just Tetralogy; this operation also, however, had long-term complications.[41-3]

Many other shunting operations were then developed for other sick infants and children. Other major palliative operations designed for patients with Tetralogy and other cyanotic lesions were the ascending-aorta-to-pulmonary-artery anastomosis first described by Waterson[44] and the superior-vena-caval-right-pulmonary-artery anastomosis devised by Glenn.[45]

Modifications of the subclavian-artery-

pulmonary-artery anastomosis have included lengthening the subclavian portion by vein[46] arterial graft,[47] artificial graft[48] or use of arterial homograft in the same manner.[48, 49] Anastomosis of the ascending aorta to the main pulmonary trunk,[50] division of the right pulmonary artery with anastomosis end-to-side to the ascending aorta.[51] Cooley[52] used a transpericardial approach to the operation of Waterston.

Grafts between the ascending or the descending aorta and pulmonary artery or subclavian and pulmonary artery were also devised.[51-53-55]

The long-term evaluation of all these palliative procedures has shown grafting results but also many short- and long-term complications.[56-58]

The first intracardiac repair on a child with Tetralogy was performed by C. Walton Lillehei at the University of Minnesota on August 31, 1954, using cross circulation from a donor.[33, 59] Further technical developments soon followed and allowed great advances,[33] such as the "heart-lung machine" and various types of oxygenators which allowed surgical techniques to become more sophisticated.

In the following 20 years, variations of this operation were performed in older children[60] at numerous medical centers, at first with a relatively high risk. Then, as techniques improved, repair of Tetralogy was performed with lower mortality and was then extended to younger children and infants. All children with the various forms of shunting procedures in infancy subsequently have needed intracardiac repair. In expert hands, the morbidity and mortality of repair is now much lower than previous years and there is no difference in mortality even when a shunt must be removed.[61, 62]

Developments such as right ventricular outflow patches and conduits for those with true or virtual atresia have been major advances. The age at which repair has been safely achieved has become lower and lower.[62-4] Now cases are repaired using deep hypothermia and circulatory arrest with remarkably good early results.[65-68] This is quite an advance since the first use of hypothermia in medicine in neurosurgery in 1936.[69] Just as with the patients Dr. Taussig followed for so many years, it remains to be seen what the long term problems may be.



Fig 3
Willis Potts. (Reproduced by permission of the Children's Memorial Hospital of Chicago.)

It has been nearly 300 years since Stensen noted the first "Tetralogy," nearly 90 since Fallot described the anatomy and only 30 years since the first courageous surgeons operated upon these children. During the last three decades, advances in both medical and surgical care have been astounding and the lives of these unfortunate children have been immeasurably improved. Now that techniques are available, early intracardiac repair seems the trend for the future; this, of course, depends upon perfection in diagnosis prior to surgery. The current pioneers are those developing the techniques of low-risk early repair and those testing the experimental embryology and application of the theories of Van Praagh to prevent the development of the Tetralogy of Fallot.

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References

1. Nadas, A. S.: Pediatric Cardiology, Philadelphia, W. B. Saunders, 1972, p. 683.
2. Gasul, B. M., Arcilla, R. A., Lev, M.: Heart Disease In Children, Philadelphia, J. B. Lippincott, 1966, p. 571-616.
3. Stensen, N.: Quoted by H. I. Goldstein in discussion of Jarcho, S.: Giovanni Battista Morgagni. Bull. Hist. Med. **22:**503-527, 1948.
4. McManus, J. F. A.: The History of the Pathology of the Heart in Gould, S. E.: (Ed): Pathology of the Heart and Blood Vessels, Springfield, Ill., C. C. Thomas, 1968, p. 3-19.
5. Willius, F.A. and Keys, T. E.: Classics of Cardiology, New York, Henry Schuman and Dover Publications, p. 688-90, 99-104. 1942.
6. Bennett, L. R.: Sandifort's "Observations," Chapter 1, Concerning a very rare disease of the heart; 1. tetralogy of Fallot or Sandifort? Bull. Hist. Med. **20:**539-70, 1946.
7. Taussig, H. B.: Congenital Malformations of the Heart Vol. II. Specific Malformations. Cambridge, Harvard Univ. Press, 1960, p. 3-61.
8. Peacock, T. B.: On Malformations of the Human Heart, etc. with Original Cases and Illustrations. (2nd ed.), London, Churchill, 1866, p. 32-60.
9. Corvisart, J. N.: An essay on the organic diseases and lesions of the heart and great vessles. Trans. by J. Gates. Boston, Bradford and Read, 1812, p. 207-9, 231-2.
10. Fallot, A.: Contribution a l'anatomic pathologique de la maladie bleue (cyanose cardiaque). Marseille Medical **25:**418-20, 1888.
11. White, P. D. and Sprague, H. B.: The tetralogy of Fallot: report of a case in a noted physician who lived to his sixtieth year. J. Amer. Med. Assn., **92:**787-91, 1929.
12. Hayden, T.: The Diseases of the Heart and of the Aorta. Philadelphia, Lindsay and Blakiston, 1875, p. 302.
13. Russell, W.: Investigations into some morbid cardiac conditions. Edinburgh, Bell and Bradfute, 1886.
14. Dujardin-Beaumetz, G.: The Modern Treatment of Diseases of the Heart, (Trans. E. P. Hurd), Detroit, G. S. Davis, 1887.
15. Sansom, A. E.: The Diagnosis of the Heart and Thoracic Aorta, London, Charles Griffin Co., 1892, p. 289-91.
16. Broadbent, W. H.: Heart Disease, New York, William Wood & Co., 1898.
17. Broadbent, W. H.: Heart Disease, New York, William Wood, 1900, p. 228-30.
18. Greenwood, R. D.: Marcus P. Hatfield — The first pediatrician at Northwestern. Ill. Med. J. **145:** 62-3, 79, 1974.
19. Babcock, R. H.: Diseases of the Heart and Arterial System, New York, Appleton, 1903.
20. MacKenzie, J.: Diseases of the Heart, New York, Oxford Univ. Press, 1910, p. 256-7.
21. Hirschfelder, A. D.: Diseases of the Heart and Aorta, Philadelphia, J. B. Lippincott, 1910., p. 421-60.
22. Sutherland, G. A.: The Heart in Early Life, London, Oxford Univ. Press., 1914.
23. Garrod, A. E., Batten, F. E., Thursfield, H., Peterson, D: Diseases of Children, New York, William Wood & Co., 1929.
24. White, P. D.: Heart Disease, New York, MacMillan, 1931, p. 305-321.
25. Abbott, M. E.: Atlas of Congenital Cardiac Disease, New York, American Heart Association, 1936, p. 46-7.
26. Spitzer, A.: Ueber den Bauplon des normaleu and missbildeten Herzens; Versvch einer phylogenetischen Theorie. Virchows Arch f. path Anat. **243:**81-272, 1923.
27. Edwards, J. E., Carey, L. S., Neufeld, H. N., Lester, R. G.: Congenital Heart Disease: Correlation of Pathologic Anatomy and Angiocardiography., Philadelphia, W. B. Saunders, 1965, p. 399-471.
28. Lev. M.: Autopsy Diagnosis of Congenitally Malformed Hearts, Springfield, C. C. Thomas, 1953.
29. Lev, M. and Eckner, F. A. O.: The Pathologic anatomy of tetralogy of Fallot and its variations. Dis. Chest. **45:**251, 1964.
30. Van Praagh, R., Van Praagh, S., Nebesar, R. A., Muster, A. J., Sinha, S. N., and Paul, M. H.: Tetralogy of Fallot: Underdevelopment of the pulmonary infundibulum and its sequelae. Amer. J. Cardiol. **26:** 25-33, 1970.
31. Van Praagh, R.: Conotruncal Malformations in Heart Disease in Infancy, ed. by Barratt-Boyes, B. G., Neutze, J. M. and Harris, E. A.: Edinburgh, Churchill-Livingstone, 1973, p. 141-194.
32. Van Praagh, R.: The segmental approach to diagnosis in congenital heart disease. Birth Defects Orig. Article Series V. 8 No. 5, Baltimore, Williams and Wilkins, 1972, p. 4-23.
33. Johnson, S. L.: The History of Cardiac Surgery 1896-1955: Baltimore, Johns Hopkins Press, 77-85, 113-19, 137-58, 1970.
34. Taussig, H. B.: On the evolution of our knowledge of congenital malformation of the heart. Circ. **31:** 768-777, 1965.
35. Levy, S. E. and Blalock, A.: Experimental Observations on the effect of connecting by suture the left main pulmonary artery to the systemic circulation. J. Thor. Surg. **8:**525-30, 1938.
36. Blalock, A. and Taussig, H. B.: The surgical treatment of Malformations of the Heart. J. Amer. Med. Assn. **128:** 189-202, 1945.
37. Taussig, H. B., Crawford, H., Pelargonio, S., and Zachariodakis, S.: Ten to 13 years followup on patients after Blalock-Taussig Operation. Circ. **25:**630-34, 1962.
38. Albers, W. H. and Nadas, A. S.: Unilateral chronic pulmonary edema and pleural effusion after systemic-pulmonary artery shunts for cyanotic congenital heart disease. Am. J. Cardiol. **19:**861-866, 1967.
39. Potts, W. J., Smith, S., and Gibson, S.: Anastomosis of the aorta to a pulmonary artery. J. Amer. Med. Assn. **132:**627-31, 1946.
40. Greenwood, R. D.: Willis J. Potts 1895-1968. J. Kans. Med. Soc. **75:** 14-20, 1974.
41. Cole, R. B., Muster, A. J. Fixler, D. E. and Paul, M. H.: Long term results of aorta-pulmonary anastomosis for tetralogy of Fallot. Circ. **43:**263-271, 1971.
42. Von Barnuth, G., Ritter, D. G., Frye, R. L., Weidman, W. H., Davis, G. D., and McGoon, D.C.: Evaluation of patients with tetralogy of Fallot and Potts anastomosis. Am. J. Card. **27:**259-263, 1971.
43. Paul, M. H., Miller, R. A., and Potts, W. J.: Long term results of aortic-pulmonary anastomosis for tetralogy of Fallot. Circ. **23:**525-33, 1961.
44. Waterston, D. J.: Treatment of Fallot's tetralogy in infants. Rozhl Chir **41:**181, 1962.
45. Glenn, W. W. L. & Patino, J F., Circulatory bypass of the right heart. 1. Preliminary observations on the direct delivery of vena caval blood into the pulmonary arterial circulation-azygous vein-pulmonary artery shunt. Yale J. Biol. Med. **27:**147-151, 1954.
46. Johnson, J., Kirby, C. K., Greifenstein, F. E. and Castillo, A.: The experimental and clinical use of vein grafts to replace defects of large arteries. Surgery **26:** 945-56, 1949.
47. Gross, R. E., Bill, A. H. Jr. and Peirce, E. C. II : Methods for preservation and transplantation of arterial grafts. Observations on arterial grafts in dogs. Report of transplantation of preserved arterial grafts in 9 human cases. Surg. Gynec. Obstet. **88:**689-701, 1949.
48. Patient records, The Children's Hospital Medical Center, Boston.
49. Herbst. M.: Die Verwendung von arteriellen Homiotransplantaten in der Chirurgie des Herzens und der grossen Gefasse Zbl Chir **83:** 486, 1958.
50. Davidson, J. S.: Anastomosis between the ascending aorta and the main pulmonary artery in the tetralogy of Fallot. Thorax **10:**348-50, 1955.
51. Shumacker, H. B. Jr. & Mandelbaum, I.: Ascending aortic-pulmonary artery shunts in cyanotic heart disease. Surgery **52:**675-8, 1962.
52. Cooley, D. A. and Hallman, G. L.: Intrapericardial aortic-right pulmonary arterial anastomosis. Surg. Gynec. Obstet **122:**1084-6, 1966.
53. Michaud, P., Termet, H., and Verney, R.: Pontage prothetique aorte ascendante artere pulmonaire diorte moyen de "depannage" dans certains cas de tetralogie de Fallot. Ann. Chir. **16:** 859, 1962.
54. Klinner, W. Von, Pasini, M. and Schaudig. A.: Anastomose zwischen Systemund Lungenarterie mit Hilfe von Kunstoffprothesen bei cyanotischen Herzvitien. Thoraxchirurgie **10:** 68-75, 1962.
55. Semb, G., Hemodynamic and hematological studies on the effect of the systemic-pulmonary artery shunt. Special issue devoted to the VIII Congress of the International Cardiovascular Society, Vienna. J. Cardiov. Surg. p. 202., 1967.
56. Greenwood, R. D., Rosenthal, A., Nadas, A. S., Bernard, W. F., Freed, M., Castaneda, A. R.: Ascending Aorta-Pulmonary Artery Anastomosis for Cyanotic Congenital Heart Disease: Natural History in 208 patients with the alternative of primary repair in infants with tetralogy of Fallot., unpublished manuscript.
57. Reitman, M. J., Galioto, F. M. Jr., El-Said, G. M., Cooley, D. A., Hallman, G. C., and McNamara, D. G.; Ascending Aorta to Right Pulmonary Artery Anastomosis Circ. **49:**952-957, 1974.
58. Tay, D. J., Engle, M. A., Ehlers, K. H., and Levin, A. R.: Early results and late developments of the Waterston Anastomosis. Circ. **50:**220-229, 1974.
59. Lillehei, C. W., Cohen, M., Warden, H. E., Read, R. C., Aust, J. B., DeWall, R. A. and Varco, R. L.: Direct Vision intracardiac surgical correction of the tetralogy of Fallot, pentalogy of Fallot, and pulmonary atresia defects. Ann. Surg. **142:** 418-445, 1955.
60. Wolf, M. O., Landtman, B., Neill, C. A., Taussig, H. B., Total Corrections of Tetralogy of Fallot, I. Follow up Study of 104 cases. Circ. **31:**385-93, 1965.
61. Sade, R. M., and Castaneda, A.: Personal Communication, 1975.
62. Kirklin, J. W. and Karp, R. B.: The Tetralogy of Fallot from a surgical viewpoint, Philadelphia, W. B. Saunders, 1970.
63. Puga, F. J., DuShane, J. W., McGoon, D. C.: Treatment of tetralogy of Fallot in children less than 4 years of age. Journal Thorac. Cardiovasc. Surg. **64:**247-53, 1972.
64. Sunderland, C. O. Matarazzo, R. G., Lees, M. H., Menashe, V. D., Bonchek, L. I., Rosenberg, J. A. and Stan, A.: Total correction of tetralogy of Fallot in Infancy: Postoperative Hemodynamic Evaluation. Circ. **48:**398-405, 1973.
65. Greenwood, R. D., Rosenthal, A., Nadas, A. S., Freed, M., and Castaneda, A. R.: Ascending Aorta-Pulmonary artery anastomosis for cyanotic congenital heart disease. Amer. J. Cardiol. **35:**141, 1975.
66. Barratt-Boyes, B. G.: Complete Correction of cardiovascular malformations in the first two years of life using profound hypothermia in Barratt-Boyes, B. G., Neutze, J. M., Harris, E. A.: Heart Disease in Infancy, Edinburgh, Churchill-Livingstone, 1973, p. 25-36.
67. Ker, A. R. and Barratt-Boyes, B. G.: Surgery of Tetralogy of Fallot in Infancy: Comparison of Shunt Palliation and Primary Intracardiac Repair in Barratt-Boyes, B. G., Neutze, J. M., Harris, E. A.: Heart Disease in Infancy, Edinburgh, Churchill-Livingstone, 1973, p. 197-207.
68. Castaneda, A. R., Lamberti, J., Sade, R. M., Williams, R. G., Nadas, A. S.: Open heart surgery during the first three months of life. J. Thor. Cardiovasc. Surg. **68:**719-31, 1974.
69. Fay, T. and Henry, G. C.: Correlation of foreign body segmental temperature and its relation to the location of carcinomatos metastasis. Surg. Gynec. Obstet. **66:**512-24, 1938.

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Diagnostic Patterns in Disability—Oklahoma and the Nation

FLOYD MOORMAN, MD

This short statistical analysis of data compiled by the Office of Research and Statistics, Social Security Administration, shows the extent and nature of Oklahoma's participation in the Social Security disability insurance program.

Under the provisions of the Social Security disability program, the nation's largest disability plan, a worker under 65 years of age can receive monthly benefits if he or she becomes unable to work due to a mental or physical impairment that has lasted — or is expected to last — at least 12 months, or is expected to result in death.

Almost 80 million workers can count on monthly cash benefits in the event of such severe and extended disability. In addition, the dependents of these workers are also eligible for monthly benefits. Nearly 2.4 million workers and 1.8 million dependents are now receiving disability benefits at the rate of more than $7.5 billion a year.

Currently, 34,600 disabled workers in Oklahoma are receiving $7,500,000 a month in benefits. In addition, 7,000 wives or husbands of disabled workers and 19,800 children of disabled workers in Oklahoma are receiving benefits at a monthly rate of $500,000 and $1,200,000, respectively. The latest year for which tabulated data is available showing disabled worker diagnostic patterns by States is 1972 and data for the succeeding years will most likely show a gradual increase. Disabled workers in Oklahoma who began receiving benefits in that year constituted 5,594 of the 455,398 new beneficiaries nationwide.

Table 1 compares the frequency of diagnostic groups in Oklahoma with the US overall. It shows that diseases of the circulatory system comprised the largest diagnostic group in the country in 1972. Diseases of the musculoskeletal system and mental disorders, includ-

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A 1925 graduate of the University of Louisville School of Medicine, J. Floyd Moorman, MD, is now Supervisor of the Disability Insurance Unit of the Department of Institutions, Social and Rehabilitative Services of the Oklahoma Public Welfare Commission of the State of Oklahoma. He is Associate Professor of Medicine Emeritus of the University of Oklahoma Health Sciences Center. Doctor Moorman is a Fellow of the American College of Physicians and the American College of Chest Physicians.

Table 1.—Social Security Worker Disability Allowances 1972—Diagnostic Groups

Diagnostic Group	US		Oklahoma	
Diseases of the circulatory system	146,684	32.2	1,602	28.6
Diseases of the musculoskeletal system	75,923	16.7	1,046	18.8
Mental, psychoneurotic, and personality disorders	45,253	9.9	471	8.4
Neoplasms	43,667	9.6	565	10.1
Accidents, poisonings, and violence	31,728	7.0	483	8.6
Diseases of the respiratory system	33,038	7.3	459	8.2
Diseases of the nervous system and sense organs	28,216	6.2	270	4.8
Endocrine system, metabolic, and nutritional diseases	17,352	3.8	249	4.5
Diseases of the digestive system	13,369	2.9	180	3.2
Infective and parasitic diseases	8,627	1.9	123	2.2
Other	11,541	2.5	146	2.6
Total	455,398	100.00[1]	5,594	100.00[1]

[1] Figures may not total 100% due to rounding.

ing psychoneurotic and personality disorders, were the second and third largest diagnostic groups, respectively. All states do not, however, follow this pattern.

Within these overall diagnostic groups, the most prevalent *primary diagnosis* in both Oklahoma and the nation in 1972 was chronic ischemic heart disease. Oklahoma recorded 1,119 cases that year. The nation's second most common primary diagnosis, degenerative or osteoarthritis, accounted for 468 cases in Oklahoma. Following these, in order of decreasing national prevalence, was displacement or rupture of intervertebral disc, with Oklahoma reporting 261 cases, followed by schizophrenia with 129 cases in Oklahoma. There were 359 cases of emphysema in Oklahoma; 143 cases of diabetes mellitus. Rheumatoid arthritis and allied conditions accounted for 160 cases in Oklahoma that year. Acute cerebrovascular disease, listed eighth among the most prevalent primary diagnoses in 1972, recorded 13 cases in Oklahoma; malignant neoplasm of trachea and lung 154 cases; and other respiratory diseases ranked tenth in Oklahoma with 24 cases.

Additional information about the Social Security disability program in Oklahoma can be obtained through the Disability Insurance Unit, P.O. Box 25352, Oklahoma City, Oklahoma 73125, Telephone: (405) 525-3366. □

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Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Cromolyn Sodium — Unauthorized Uses

LEON HOROWITZ, MD

Cromolyn Sodium has been approved for use by inhalation, for the treatment of asthma. Its topical effectiveness suggests other possible uses, particularly for allergic rhinitis.

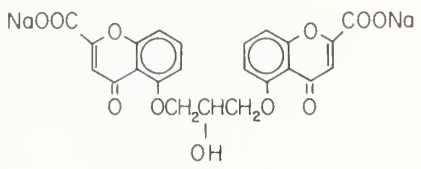
Cromolyn sodium* has been available for use in this country since approved by the Food and Drug Administration (FDA) in August, 1973.[1] Before that, cromolyn sodium was in general clinical use in the United Kingdom and other foreign countries for about five years. Cromolyn sodium is authorized for use in this country by the FDA for the control of asthma by the inhalation of the dry powder. It is being used in foreign countries in other ways[2,3] and for other allergic conditions.[4-8] The purpose of this paper is to describe two unauthorized uses of cromolyn sodium and to discuss the prescription of approved drugs for uses unapproved by the FDA.

CASE REPORTS

1. J.B., a three-year-old male, was first noticed to have rapid noisy breathing at two weeks of age. At five months of age he was first hospitalized with asthma and by nine months of age had been hospitalized five times in status asthmaticus for which heroic resuscitative measures were required to sustain life. By one year of age, he was receiving alternate-day steroids and a full therapeutic regime of medication for asthma. His mother, on her own, would frequently increase the steroids, in both frequency and dose, whenever attacks of asthma threatened. The child had been treated with intermittent positive pressure breathing (IPPB) in the hospital and, therefore, was familiar with and receptive to such treatment. He could not cooperate, because of his age, in the inhalation of dry cromolyn sodium powder. In an attempt to further control the asthma and decrease the use of steroids he was started on a four-times-daily (q i d) routine of IPPB containing 0.25cc of isoetharine ("Bronkosol"-Breon) in 2cc sterile water in which had been dissolved one capsule of cromolyn sodium. In the six-months since this therapy has been instituted, he has required epinephrine on only two occasions and we have been able to decrease the steroid dose. The cromolyn has been well-tolerated with no complications.

2. G.W., a 16-year-old white male, had asthma since one year of age, requiring hospitalization and, from then on, had frequent episodes, more in the winter, requiring frequent treatment with epinephrine and occasional steroids. At three years of age, he started having peren-

*Aarane, Syntex and Intal, Fisons



CROMOLYN SODIUM (INTAL®, LOMUDAL®)
(disodium salt of 1,3-bis [2-carboxychromon-5-yloxy]-2-hydroxypropane)

Fig 1

nial allergic rhinitis with exacerbations in the spring and fall. He did not respond to antihistamine-decongestant preparations but was helped by the use of a Decadron phosphate nasal spray ("Turbinaire"-Merck, Sharp & Dohme). Allergy skin-testing revealed strong pollen-and environmental-inhalant sensitivity and a few food reactions. Allergy immunotherapy was instituted along with environmental modification and dietary control. The asthma responded well and has been completely eliminated but the rhinitis has been refractory. In April, 1975 cromolyn nose drops were started. One capsule of cromolyn was dissolved in one teaspoon of water each morning and administered as nose drops on a qid basis. While not giving complete relief, this modality of therapy has helped more than any antihistamine-decongestant preparation.

DISCUSSION

Cromolyn sodium is the disodium salt of 1,3-bis (2-carboxychromon-5-yloxy) -2-hydroxy propane. A white powder, soluble in water, it is poorly absorbed orally. (Figure 1) The drug was developed in England, by Fisons Corporation, starting in 1956 working with the drug Khellin (Figure 2), which had been studied since 1930 as a coronary-artery-relaxant and had been in use in that manner since 1949. Khellin had been extracted from an Eastern Mediterranean plant, Ami Visnaga (Figure 3), whose brew had been used for years in that area as an anti-colic preparation and whose Arabic name is *KHELLA*. Dr. Roger Altou-

Chemical Structure of the Chromone, Khellin

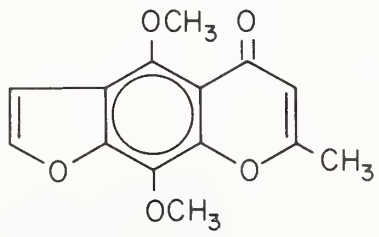


Fig 2



AMMI VISNAGA

Eastern Mediterranean plant from which khellin is obtained.

Fig 3

nyan, a clinical pharmacologist with Fisons, was an asthmatic, and he served as a clinical model for testing of the drug. By 1963, it was found that cromolyn sodium could inhibit asthma caused by bronchial challenge and in 1965, field trials began in Great Britain where it was released for clinical use in 1968. Extensive clinical trials in this country led to its eventual release in 1973.

Cromolyn sodium is thought to act by directly affecting the mast cell membrane to prevent degranulation and release of chemical mediators in response to antigen-antibody and other stimuli. It is effective in decreasing the frequency and severity of asthma in approximately 80% of asthmatics and in many the asthma is completely eliminated. In many intractable asthmatics the dose of steroids may be decreased and in some cases eliminated.[9]

A 1952 graduate of New York University College of Medicine, Leon Horowitz, MD, has been certified by the American Board of Pediatrics, the Sub-Board of Pediatric Allergy and the American Board of Allergy and Immunology. Doctor Horowitz is a Fellow of the American Academy of Allergy, the American College of Allergy and the American Academy of Pediatrics. He is also affiliated with the American Thoracic Society, the American Heart Association (Cardiopulmonary Section), and the American Association of Certified Allergists.

Since it is poorly absorbed from the gastrointestinal tract, cromolyn sodium is used in the treatment of asthma by inhalation of the dry powder. It is administered in a capsule of 20 mg of cromolyn in a micronized form together with 20 mg of lactase powder added to improve the flow properties. The capsule is administered with a turbo-inhaler in which it is punctured and then powered by direct inhalation. This procedure requires a certain degree of understanding and dexterity, which creates difficulties for infants and young children and some older adults. In these cases it is frequently possible to administer the drug by nebulization of aqueous solution delivered by IPPB.[2,3] It appears that this mechanism of delivery may be as effective as that which is approved for general use.

Since cromolyn apparently is effective by topical application to the mucus membrane of the affected target organ, it has been used, with good results in other allergic diseases in which the target organ is accessible for topical application.[4-8] It has been approved for topical use for nasal allergy in the United Kingdom where it is marketed as Rynocrom ("Cromolyn," Fisons). It is used both by inhalation of the dry powder directly into the nose or by the instillation of an aqueous solution in a drop or nasal spray.[10] The powder may also be blown into the nose, if the patient is so obstructed that it can not be inhaled, by the use of a hand powered powder insufflator.* There has been wide acceptance of the medication because of its relative lack of undesirable side effects, such as the sedative effect frequently seen with antihistamines and the stimulant effect frequently seen with decongestants.

The FDA has recently been approved by the United States Supreme Court as having the final word with regard to marketing of new drugs and with regard to certification of safety and efficacy.[11] The pertinent information on prescription drugs is contained on the package insert which includes the *INDICATIONS*. These *INDICATIONS*, however, do not limit the physician in the use of an approved drug for unapproved indications. "Once the new drug is in the pharmacy after interstate shipment, the physician may, as a part of the practice of medicine, lawfully prescribe a different dosage for his patient, or may otherwise vary the conditions of use from those approved in the package insert without informing or obtaining the approval of the Food and Drug Administration."[12]

"Physicians have been concerned that the failure to follow the labeling of a drug may render them unduly liable for malpractice. Although labeling, along with medical articles, texts, and expert opinion, may constitute evidence of the proper practice of medicine, it alone is not controlling on this issue. The labeling is not intended either to preclude the physician from using his best judgment in the interest of the patient, or to impose liability if he does not follow the package insert."[13]

The advent of the FDA and PSRO should not reduce the practice of medicine to "cook-bookery" in which we practicing physicians lose our initiative and sacrifice our scientific curiosity to the expediency of "going by the book." When we do, our patients will suffer and we will lose both the art and the science of medical practice. The two cases described here illustrate how we can continue to help our patients with a little ingenuity and willingness to innovate.

*De Vilbiss #38

SUMMARY

Two cases in which cromolyn sodium is used other than in the approved manner are described. The development and mode of action of cromolyn sodium is briefly reviewed. The implications of the use of drugs for other than FDA approved purposes is discussed. □

REFERENCES

1. FDA Drug Bulletin, August, 1973.
2. Hobday, J. D. The Use of Nebulized Intal in Asthma. Med. J. Australia 1 (19): 772, 1974.
3. Williams, H. E, Phelan, P. D. Administration of Disodium Cromoglycate to Young Children. Brit. Med. J. 2: 488, 1973.
4. Viner, A. S. Nasal Disodium Cromoglycate (DSCG). Ned. Tijdschr. Geneeskd. 119: 1196-1198, 1975.
5. Fragerberg, E., Zetterstrom, O. A Trial of Disodium Cromoglycate in Perennial Rhinitis. Acta Allergol. 30: 63-72, 1975.
6. Hyams, S. W., Bialik, M., Neumann, E. Clinical Trial of Topical Disodium Cromyglycate in Vernal Kerato-Conjunctivitis. J. Ped Ophthalmal. 12(2): 116-118, 1975.
7. Werthenschlag, J. Les Allergies d'Origine Aliamentaire — Interet du Cromoglycate de Sodium par vore Buccale. (Allergies of Alimentary Origin — Oral Administration of Disodium Cromoglycate). Nouv. Presse 4(14): 1043, 1975.
8. Kingsley, P. J. Oral Sodium Cromoglycate in Gastrointestinal Allergy. Lancet 2: 1011, 1974.
9. Godfrey, R. C. and Howell, J. B. L. Sodium Cromoglycate: A Clinical View. Drugs 7:161-163, 1974.
10. Manners, B. T. B. A Comparison of Sodium Cromoglycate Nasal Solution and Powder in Hay Fever. Brit. J. Clin. Pract. 29(6): 153-154, 1975.
11. 512 SED 2nd 688, 1975. National Nutritional Foods, Inc. vs. Weinberger.
12. Federal Register, Vol. 37, No. 158, p 16503, August 15, 1972.
13. FDA Drug Bulletin, October, 1972.

109 Utica Square Medical Center, Tulsa, Oklahoma 74114

News From The Oklahoma State Department of Health

SWINE INFLUENZA

The pharmaceutical industry will produce about 20 million doses of bivalent vaccine containing A/Victoria and A/swine strains. This preparation should be available late July-early August, and is recommended for the population at high risk. The high risk population is defined as in previous years with previously produced influenza vaccines. We anticipate that the majority of the bivalent vaccine will be used in nursing home populations and administered primarily in physicians' offices to high risk patients. The vaccine will be distributed through local health departments and will be free of charge. We do not plan to administer bivalent vaccine in mass community campaigns.

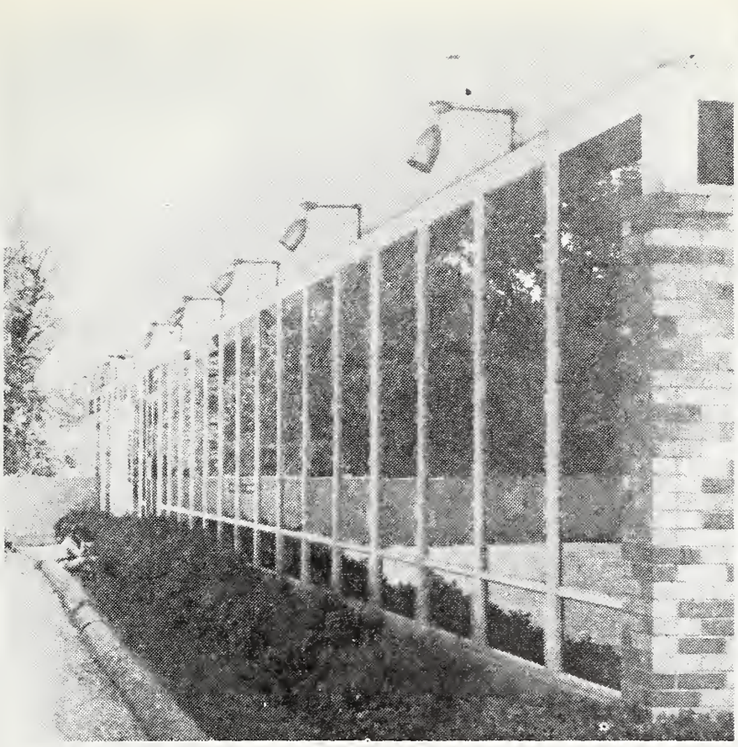
The monovalent vaccine containing only A/swine strain is expected to be at peak production by mid-September. This vaccine will be offered in mass campaigns as well as through physicians' offices. There will be no charge for the vaccine *per se,* but physicians are expected to charge a reasonable cost for administering the vaccine in their offices. As with the bivalent vaccine, the monovalent preparation will be available through local health departments.

It is anticipated that the monovalent A/swine strain vaccine will be received from the pharmaceutical industry over a time period of three to four months. This will require a regionalization of the distribution system, ie, the State Department of Health will not be able to provide the vaccine to the entire state population at one time. The state population will be divided into districts or regions and as vaccine becomes available, selected population groups will be offered the vaccine through physicians, local health departments, and community based clinics. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR APRIL, 1976

DISEASE	April 1976	April 1975	March 1976	Total To Date 1976	1975
Amebiasis	—	1	—	2	4
Brucellosis	—	—	—	—	2
Chickenpox	312	159	329	1207	723
Encephalitis, Infectious	1	4	3	6	13
Gonorrhea (Use Form ODH-228)	997	1104	1138	4319	4069
Hepatitis, A, B, Unspecified	95	60	106	658	330
Leptospirosis	—	—	—	—	—
Malaria	—	—	—	—	1
Meningococcal Infections	2	1	4	17	8
Meningitis, Aseptic	3	1	2	8	9
Mumps	92	24	193	506	85
Rabies in Animals	17	8	12	44	50
Rheumatic Fever	1	4	2	4	5
Rocky Mountain Spotted Fever	3	3	1	5	11
Rubella	9	10	7	43	67
Rubella, Congenital Syndrome	—	—	—	—	—
Rubeola	17	3	14	219	20
Salmonellosis	9	6	14	51	54
Shigellosis	34	9	42	107	149
Syphilis, Infectious (Use Form ODH-228)	4	7	11	39	36
Tetanus	—	—	—	—	—
Tuberculosis, New Active	37	22	34	127	115
Tularemia	—	—	—	—	—
Typhoid Fever	—	—	—	—	—
Whooping Cough	—	8	—	1	11

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OSMA Officer Refutes Mayo Charges

Charges that physicians and hospitals have increased their fees by nearly 100 per cent are totally untrue, says M. Joe Crosthwait, MD, OSMA Vice-President. Doctor Crosthwait told a reporter from an Oklahoma City newspaper that the medical profession has been a "victim of inflation" and not a cause. His statements came in an interview following a recent Oklahoma speaking tour by Charles Mayo, MD, of Mayo clinic fame.

Although Doctor Mayo's expressed purpose in coming to Oklahoma City and Tulsa was to promote the cause of national health insurance, he spent much of his time explaining the concept behind a Minnesota health maintenance organizaion where he works. Mayo pointed to HMO's as at least one method of holding down rising medical costs which he holds doctors and hospitals responsible for. Another method of holding down costs, he told an audience at St. Luke's Methodist Church in Oklahoma City, is national health insurance.

In Doctor Crosthwait's follow-up interview with the *Oklahoma Journal* he blamed federal intervention, particularly federal price freezes in 1971, as the principal cause for the rapid increase in medical costs. Crosthwait explained that he was unable to raise his fees for three years, during which time "my costs alone for supplies went up 30 to 40 per cent." He said doctors have had to play "catch-up" since the price freeze was lifted.

Another principal contributing factor, Crosthwait told the newspaper, is the ever increasing malpractice insurance problem. He pointed out that rates increased by 100 per cent in just one year stating, "There's no way we can absorb that. It has to be reflected in patient care costs."

In response to Mayo's claim that doctors are responsible for high Medicare expenses, Crosthwait said the incidence of physicians taking advantage of the Medicare system is very small. Instead of looking at physicians as the cause, look to federal bureaucracy, he said.

Crosthwait said when Medicare was begun, the peak cost of the program was estimated to reach about $10 billion. Instead, he said, it cost about $19 billion last year and may run as high as $23 billion this year.

"Anytime the government gets into something, the costs are never lowered," Crosthwait said. He indicated the same would be true for a system of national health insurance.

Crosthwait also said Mayo's claims for HMO's are misleading. He said Doctor Mayo failed to point out that the government is subsidizing all but one HMO in the nation. Congress appropriated $73 million for HMO subsidies in 1975, Crosthwait told the *Journal.*

The way to improve medical care is through the present system, said Crosthwait. He said a national health insurance plan is unnecessary. □

Donor Card Bill Passes

A bill passed recently by the Oklahoma Legislature will both step-up the body organ retrieval system and protect delicate organs from lengthy and distructive time lags. The bill, H.B. 1890, calls for the Oklahoma Department of Public Safety to provide a space on all driver's licenses for persons who wish to donate body organs.

Under the new law, future driver's licenses issued by the Department of Public Safety will have a space available for persons who wish to donate body organs, parts, or the entire body for the purposes of transplantation, therapy, medical research, or education. The department will specify on the application or renewal form that the holder is an organ donor under the guidelines of the Uniform Anatomical Gift Act. The gift act, passed by the Legislature in 1969, established procedures for the donation and removal of organs or parts of the body.

When a person applies for a driver's license or for renewal, he or she will be given an organ donor card. If the applicant wishes to be an organ donor, once the card is filled out and signed it will be returned to the Department of Public Safety and filed at a central repository. The notation on the driver's license will, under the new law, constitute sufficient legal authority for the removal of designated organs upon the donor's death. The notation can be removed only upon 30 days written notice to the department.

This act does not apply to temporary licenses, those issued for driver's education purposes, or to licenses issued to any person under the age of 18. □

Conference on Breast Cancer Planned

The controversy over the treatment of breast cancer will be explored at a conference to be held in Oklahoma City in November of this year. The conference, sponsored by the Oklahoma Medical Research Foundation's Oklahoma Hospitals Breast Cancer Control Network, will feature panel discussions and debates over questions such as the timing of biopsies and treatment, and the types of treatments which should be used.

The two-day seminar on cancer treatment will be held November 10th and 11th at the Lincoln Plaza Forum and will address the wide variability of treatment choices available to physicians. It will be organized under two general topics: "Controversies in Breast Cancer Treatment" and "New Horizons in the Treatment of Solid Tumors."

The session on breast cancer treatment will feature a discussion-format designed to fully explore such questions as timing of biopsies and treatment; the pathologist's role as a member of the decision-making team; the extent and type of surgery; the role of radiation therapy; adjutant chemotherapy; and the treatment of advanced disease.

The session of the treatment on solid tumors will focus on melanomas, carcinomas of the GI tract, and sarcomas with particular emphasis on cancer chemotherapy and combined modalities of therapy.

A partial preliminary roster of the conference faculty includes Stephen Gallager, MD, M.D. Anderson Hospital, Houston, Texas; Charles Huguley, MD, Emory University, Atlanta, Georgia; and William Donegan, MD, University of Wisconsin College of Medicine.

The Oklahoma Hospitals Breast Cancer Control Network, sponsor of the conference, is an educational and research activity directed by the Oklahoma Medical Research Foundation. The purpose of the Network, which consists of 24 Oklahoma hospitals, is to provide a channel of communications between research centers conducting cancer study programs. For additional information about the conference or the Network contact Arthur F. Hoge, MD, Network Director, Oklahoma Medical Research Foundation, 825 N.E. 13th Street, Oklahoma City, Oklahoma 73104, (405/235-8331). □



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Medix Broadcast Schedule Set

The summer schedule for **Medix,** a public-affairs television series on medicine and health, has been set for the June, July, and August summer months. **Medix** is broadcast in cooperation with the Los Angeles County Medical Association and is presented in Oklahoma City by KWTV. The series was awarded The Broadcast Media Award for Community Services Programs in a recent national competition organized by San Francisco State College.

The summer schedule with a brief description of each program is shown below. Consult local listings for time.

June 6th, 1976
"RELAX — TAKE IT EASY" — **Medix** focuses on stress and the stress-triggered diseases of high blood pressure, headaches and stomach upsets. Doctor Ranson Arthur suggests that tension may be linked to everything from cancer to stiff necks. Doctor Herbert De Vries gives hints on how to relax and to do away with unwanted tension.

June 13th, 1976
"IS THERE A BETTER WAY OF DYING?" — Mario Machado hosts this exploration of the inevitable featuring Doctor Edwin Schneidman, a psychologist who specializes in helping dying persons deal with death. Discussion includes: Death as society's new taboo, the modern way of dying, coping with death of a loved one, and explaining death to children.

June 20th, 1976
"PLASTIC SURGERY" — This filmed report shows that reconstructive plastic surgery is an area in medicine encompassing more than face-lifts and nose jobs. One patient featured has her face completely reconstructed after it had been demolished in an auto accident. Another, who lost her thumb in a water-skiing accident, has her big toe transplanted to her hand. A third case follows a cancer victim, who after a radical mastectomy, has her breasts reconstructed by surgeons. Precautions for viewers seeking cosmetic surgery are also presented.

June 27th, 1976
"WHEN MINUTES COUNT. . ." — Of the 1,300,000 people who have heart attacks this year, 400,000 will die without ever reaching a hosptial. This **Medix** report shows how to recognize a heart attack, whom to call, and how to give life-sustaining assistance (cardio-pulmonary resuscitation) while help is on the way.

July 4th, 1976
"TAKING THE **DIE** OUT OF DIABETES" — Five million Americans have diabetes. Filmed vignettes of six of them juxtaposed with man-on-the-street interviews show the myths and realities of the disease. Called the "hidden disease" because its symptoms often go unrecognized, diabetes is the fifth largest killer in the US, and the leading cause of blindness. Also surveyed are research attempts to find a cure for diabetes.

July 11th, 1976
"A GIFT OF LIFE" — Four patients are followed as they receive kidney transplants. Produced in cooperation with the National Kidney Foundation, this dramatic film reports the serious shortage of kidneys for people on kidney dialysis who are awaiting a transplant.

July 18th, 1976
"A GOOD SPORT PART I" — A host of Hollywood celebrities perform their favorite sports and share with viewers the joys and health benefits of each activity. Walter Matthau jogging, Elke Sommer playing tennis, Jo Anne Worley bowling, Bo Svenson playing ice hockey, and Lisa Gerritsen water-skiing. Doctor Jack Wilmore, exercise physiologist, joins host Mario Machado to evaluate the specific benefits and drawbacks of each report. Mario also undergoes a stress test to determine his physical condition prior to beginning an exercise program.

July 25th, 1976
"A GOOD SPORT PART II" — More Hollywood celebrities perform their favorite sports for the **Medix** cameras. Carol Burnett does yoga, Monty Hall plays golf, Katherine Ross rides horseback, Greg Morris plays basketball, James Franciscus swims, and Joe Campanella bicycles. Doctor Jack Wilmore, exercise physiologist, joins host Mario Machado in evaluating the health benefits of each sport. □



The newest investigator for the Oklahoma Board of Medical Examiners, Carole Smith, is shown here (third from left) at a recent meeting of the Federation of State Medical Boards in Chicago. Mrs. Smith started with the board in June, 1972, and became an investigator in January, 1976. She is shown here with Betty Rogers, Executive Secretary of the Board; M. H. Crabb, MD, Secretary, Federation of State Medical Boards; and A. Bryan Speres, MD, Secretary, Texas State Board of Medical Examiners.

Changes — Honors for Medical Board

The Oklahoma Board of Medical Examiners underwent a number of changes recently as Governor David Boren appointed new members to replace doctors whose terms had expired. At about the same time, the board's Secretary-Treasurer was honored by election to a national board.

Edgar W. Young, Jr., MD, El Reno, who had been nominated to represent the Federation of State Medical Boards at the annual meeting of the National Board of Medical Examiners was elected to membership on the national board in mid-March. Doctor Young, who serves as Secretary-Treasurer of the Oklahoma board replaced John A. Layne, MD, of Great Falls, Montana. Doctor Layne had resigned from the national board.

Earlier in the year, Governor Boren named a number of new members to the Oklahoma Board of Medical Examiners. Those named are Frank A. Clingan, MD, Tulsa, who replaces Francis R. First, Jr., MD, Checotah; Harry B. Tate, MD, Oklahoma City, who replaces Donald L. Brawner, MD, Tulsa; and Richard L. Winters, MD, Poteau, who replaces William A. Matthey, MD, Lawton. The terms of Doctors First, Brawner, and Matthey had expired.

James W. McDoniel, MD, Chickasha, was also appointed to the Medical Board. Frank L. Adelman, MD, Enid, has replaced Doctor Brawner on the FLEX committee. □

DEATHS

SAM N. MUSALLAM, MD
1913-1976

Sam N. Musallam, MD, 63, retired Oklahoma City internist, died May 13th, 1976. A native of Lebanon, Doctor Musallam was graduated from the American University of Beirut in 1937. He came to Oklahoma City in 1953. Among his medical affiliations were the Oklahoma Cardiac Society, the American Society of Internal Medicine and the Oklahoma County Heart Association. He was an honorary member of the Lebanese Cardiac and Cardiovascular Surgeons Association. Doctor Musallam was a Clinical Professor of Medicine at the University of Oklahoma Health Sciences Center.

JOHN L. LeHEW, III, MD
1930-1976

John L. LeHew, III, MD, Guthrie physician, died May 19th, 1976, in Oklahoma City. Doctor LeHew, 46, was graduated from the University of Oklahoma College of Medicine in 1955. He was a native of Guthrie and returned to his home town to practice following his internship as a flight surgeon with the US Navy. He was a member of the Flying Physicians Association and the American Academy of General Practice. He was a Fellow of the American Society of Abdominal Surgeons. In addition, he had served for 13 years on the Guthrie Board of Education including two terms as President.

ELLIS MOORE, MD
1890-1976

Retired Oklahoma City physician, Ellis Moore, MD, 85, died April 29th, 1976. A native of Pickering, Missouri, Doctor Moore, received his medical degree from the University of Oklahoma College of Medicine in 1921. He practiced for more than 50 years before retiring five years ago. In 1971, the Oklahoma State Medical Association presented Doctor Moore with a Life Membership for over a half-century of devoted service to the profession and mankind. □

Oklahoma Allergy Society Elects New Officers

During their May 9th, 1976, annual business meeting, the Oklahoma Allergy Society elected the following new officers: Leon Horowitz, MD, Tulsa, President; Robert Ellis, MD, Oklahoma City, Vice-President; and Floyd F. Miller, MD, Tulsa, Secretary-Treasurer.

Guest speaker for the meeting was Philip Norman, MD, immediate Past-President of the American Academy of Allergy. □

Stillborn Child Ruling Given By Court

The Oklahoma Supreme Court ruled in late May that the parents of a stillborn child have the right to file a wrongful death suit in this state. The precedent-breaking decision apparently opens a new area of liability for not only physicians but also for many other persons who may be directly or indirectly involved in future action. Oklahoma follows 18 other states and the District of Columbia in making this decision. OSMA attorneys are reviewing the opinion to determine its overall effect on the profession, particularly obstetrics. □

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Proceedings of the 70th Annual Session of the House of Delegates of the Oklahoma State Medical Association

OPENING SESSION

I. CALL TO ORDER:

The House of Delegates convened its 70th Annual Session in the Skirvin Plaza Hotel, Oklahoma City, Oklahoma, on April 10, 1976. The Speaker, S. N. Stone, MD, Oklahoma City, called the meeting to order at 9:40 a.m.

II. INVOCATION:

Kenneth W. Whittington, MD, Bethany, delivered the invocation.

III. REPORT OF THE CREDENTIALS COMMITTEE:

The presence of a quorum was reported by Ross Deputy, MD, Chairman, Clinton.

IV. APPOINTMENT OF COMMITTEES OF THE HOUSE:

Doctor Stone announced the appointment of the following committees to assist in the conduct of the meeting:

CREDENTIALS COMMITTEE

Ross Deputy, MD, Clinton, Chairman
F. W. Hollingsworth, MD, El Reno
Casey Truett, MD, Norman
Thomas E. Rhea, MD, Idabel
Paul N. Vann, MD, Lawton

TELLERS

Thomas C. Glasscock, MD, Ponca City, Chairman
Ray V. McIntyre, MD, Kingfisher
Harold W. Calhoon, MD, Tulsa
Frank W. Clark, MD, Ardmore
Charles Atkins, MD, Oklahoma City
Robert L. Imler, Jr., MD, Tulsa
Karl K. Boatman, MD, Oklahoma City

SERGEANTS-AT-ARMS

Harlan Thomas, MD, Tulsa, Chairman
Ed L. Calhoon, MD, Beaver
Scott Hendren, MD, Oklahoma City

REFERENCE COMMITTEE NO. I

James B. Eskridge, III, MD, Oklahoma City, Chairman
Robert G. Perryman, MD, Tulsa
Carl H. Guild, MD, Bartlesville
Beryl R. McCann, MD, Durant
Jack D. Honaker, MD, Frederick
E. C. Yeary, MD, Ponca City
Royce C. McDougal, MD, Holdenville
Don F. Rhinehart, MD, Oklahoma City
E. N. Lubin, MD, Tulsa
Claude E. Lively, MD, McAlester
Ronald H. White, MD, Oklahoma City
Don Blair, Staff

REFERENCE COMMITTEE NO. II

Jack W. Parrish, MD, Seminole, Chairman
J. William McDoniel, MD, Chickasha
Joe B. Jarman, MD, Enid
Perry A. Lambird, MD, Oklahoma City
Tony G. Puckett, MD, Oklahoma City
Roger V. Haglund, MD, Tulsa
Floyd F. Miller, MD, Tulsa
T. C. Alexander, MD, Okmulgee
M. K. Braly, MD, Woodward
Kenneth L. Evans, MD, Kingfisher
Malcolm Mollison, MD, Altus
Edgar W. Young, MD, El Reno
David Bickham, Staff

V. INTRODUCTION OF SPECIAL GUESTS:

Mrs. William B. Renfrow, retiring President of the Woman's Auxiliary to the Oklahoma State Medical Association was introduced and brought greetings to the OSMA House of Delegates.

Mrs. James L. Haddock, incoming President of the Woman's Auxiliary to the Oklahoma State Medical Association was introduced and Lowell H. Steen, MD, Trustee of the American Medical Association, Joe Boyle, MD, Trustee from Los Angeles and Mr. Dave Weihaupt, AMA staff.

Doctor Stone stated that Doctor Steen would be speaking to the delegates later in the program.

VI. PRESENTATION

Doctor Arnold G. Nelson, OSMA president, presented a Distinguished Service Award to Doctor R. Barton Carl for his dedicated service

as chairman of the OSMA Legislative Committee. Doctor Carl expressed his appreciation and commented briefly on the passage of S.B. 622.

VII. REMARKS OF THE SPEAKER:

Doctor Stone welcomed the delegates and guests to the 70th Annual Session of the Oklahoma State Medical Association. He expressed his appreciation for each person attending.

VIII. REPORT OF THE PRESIDENT:

Doctor Arnold G. Nelson presented his report and it was referred to Reference Committee No. I (A copy of the report is attached and made a part of these minutes).

IX. REPORT OF THE PRESIDENT-ELECT:

Doctor Orange M. Welborn presented his report and it was referred to Reference Committee No. I (A copy of the report is attached and made a part of these minutes).

X. REPORT OF THE CHAIRMAN OF THE BOARD:

Doctor John A. McIntyre presented information contained in the Board of Trustees Report and the Board's Supplemental Report. (Both reports are attached and made a part of these minutes).

XI. SECRETARY-TREASURER'S REPORT:

Doctor Stone stated that a copy of the Secretary-Treasurer's Report is included in the delegate portfolios (A copy of the report is attached and made a part of these minutes).

XII. INTRODUCTION OF TRANSCRIBING SECRETARIES:

Doctor Stone introduced Betty Lyles and Kathy Musson as the transcribing secretaries. He also introduced the entire OSMA staff as follows: Don Blair, David Bickham, Richard Hess, Louise Martin, Jeanette Saunders, Suzanne Wilson, Marilynn Terrel and Vicki Wheeler.

XIII. NOMINATIONS FOR ELECTIONS:

Doctor Stone announced the House would recess for ten minutes for all Trustee Districts I, II, III, IV, V and VIII to caucus.

XIV. NOMINATIONS:

The House was declared open for the nominations for the position of PRESIDENT-ELECT (One year term of office).

C. S. Lewis, Jr., MD, Tulsa, was nominated by Robert G. Perryman, MD, Tulsa.

Nominations were declared closed.

Nominations were declared open for the position of VICE-PRESIDENT (One year term of office).

M. Joe Crosthwait, MD, Midwest City, was nominated by John A. Blaschke, MD, Oklahoma City.

Nominations were declared closed.

Nominations were declared open for the position of SPEAKER, HOUSE OF DELEGATES (Two year term of office).

S. N. Stone, MD, Oklahoma City, was nominated by R. Barton Carl, MD, Oklahoma City.

Nominations were declared closed.

Nominations were declared open for the position of VICE-SPEAKER, HOUSE OF DELEGATES (Two year term of office).

Jack D. Fetzer, MD, Woodward, was nominated by M. K. Braly, MD, Woodward.

Nominations were declared closed.

Nominations were declared open for the position of DELEGATE TO THE AMA, POSITION I (Two year term of office).

Harlan Thomas, MD, Tulsa, was nominated by Edward K. Norfleet, MD, Tulsa.

Nominations were declared closed.

Nominations were declared open for the position of ALTERNATE DELEGATE TO THE AMA, POSITION I (Two year term of office).

Orange M. Welborn, MD, Ada, was nominated by David C. Ramsay, MD, Ada.

Nominations were declared closed.

Nominations were declared open for the position of DELEGATE TO THE AMA, POSITION II (Two year term of office).

Scott Hendren, MD, Oklahoma City, was nominated by Don Rhinehart, MD, Oklahoma City.

Nominations were declared closed.

Nominations were declared open for the position of ALTERNATE DELEGATE TO THE AMA, POSITION II (Two year term of office).

Rex E. Kenyon, MD, Oklahoma City, was nominated by Kenneth W. Whittington, MD, Bethany.

Nominations were declared closed.

Nominations were declared open for TRUSTEE AND ALTERNATE TRUSTEE for the following Trustee Districts (Three year term of office):

DISTRICT I.

Reporting on the Caucus of representatives from District I, the following nominations were made:

Elvin M. Amen, MD, Bartlesville, was nominated for the position of Trustee.

Edward W. Allensworth, MD, Vinita, was nominated for the position of Alternate Trustee.

DISTRICT II.

E. C. Yeary, MD, Ponca City, nominated *Thomas C. Glasscock, MD,* Ponca City.

Berno S. E. Ebbesson, MD, Ponca City, was nominated for the position of Alternate Trustee.

DISTRICT III.

Kenneth Evans, MD, Kingfisher, nominated *Ray V. McIntyre, MD,* Kingfisher, for the position of Trustee.

DISTRICT IV.

Ed L. Calhoon, MD, Beaver, nominated *M. K. Braly, MD,* Woodward, for the position of Trustee.

John X. Blender, MD, Cherokee, was nominated for the position of Alternate Trustee.

DISTRICT V.

Ed Young, MD, El Reno, nominated *F. W. Hollingsworth, MD,* El Reno, for the position of Trustee.

William M. Leebron, MD, Elk City, was nominated for the position of Alternate Trustee.

DISTRICT VII.

George H. Kamp, MD, Tulsa, was nominated for the position of Alternate Trustee.

XV. ADDRESS FROM LOWELL H. STEEN, MD, AMA TRUSTEE

Doctor Lowell H. Steen, AMA Trustee, expressed his appreciation for being able to attend the 70th Annual Session of the OSMA House of Delegates.

He referred to the OSMA Management Study Report and expressed his hopefulness that the OSMA would maintain its unified membership.

Doctor Joseph Boyle expressed his appreciation for the opportunity to attend the annual session and supported Doctor Steen's remarks.

XVI. INTRODUCTION OF COUNCIL AND COMMITTEE REPORTS AND RESOLUTIONS

Doctor Stone advised the Delegates that in order to save time, a list of reports and resolutions is included in their portfolios, and an item by item introduction would not be necessary. Doctor Stone also advised the Delegates that "late resolutions" have been approved for introduction by the Board of Trustees in accordance with the Bylaws.

XVII. ANNOUNCEMENTS.

Doctor Stone stated that the reference committees will be held at 1:00 and 1:30 p.m. in the afternoon.

He also stated that a social hour and dinner honoring the delegates of both the Oklahoma State Medical Association, and its Woman's Auxiliary would begin at 6:00 p.m. in the Imperial Ballroom.

Doctor Stone stated that the Closing Session of the House will begin at 9:30 a.m. Sunday morning in the same room.

XVIII. NECROLOGY REPORT.

The Vice-Speaker of the House of Delegates, Jack Fetzer, MD, read the Necrology Report. (A copy of the report is attached and made a part of the minutes).

XIX. ADJOURNMENT OF OPENING SESSION.

The Opening Session of the House of Delegates was adjourned at 11:35 a.m.

NECROLOGY REPORT
1975-76

Eugene G. Wolff, MD, Tulsa
Mary V. Sheppard, MD, Oklahoma City
Robert L. Loy, Jr., MD, Oklahoma City
Russell W. Lewis, MD, Sulphur
Gerald E. Cronk, MD, Tulsa
Ralph G. Obermiller, MD, Woodward
Henry C. Morrison, MD, Oklahoma City
David Carson, MD, Fairland
William G. Peterson, MD, Ada
Ruric Smith, MD, Tulsa
Maude Masterson, MD, Oklahoma City
Clarence Epley, MD, Oklahoma City
Webber Merrell, MD, Guthrie
William A. Loy, MD, Pawhuska

Robert H. Akin, MD, Oklahoma City
Earl D. McBride, MD, Oklahoma City
Glen H. Yeary, MD, Newkirk
Charles W. Joyce, MD, Fletcher
David Hudson, MD, Tulsa
Phil Devanney, MD, Belle Vista, Arkansas
Charles Tefertiller, MD, Altus
Gilbert E. Haslam, Sr., MD, Anadarko
A. M. Brewer, MD, Oklahoma City
David J. Underwood, MD, Tulsa
Nolan C. Riley, MD, Holdenville
E. Malcolm Stokes, MD, Tulsa
Ira C. Wolfe, MD, Muskogee
Richard B. Lincoln, MD, Oklahoma City

CLOSING SESSION

I. CALL TO ORDER:

The Closing Session of the 70th Annual Meeting of the House of Delegates was called to order by the Speaker, S. N. Stone, MD, at 9:40 a.m., April 11th, 1976, in the Skirvin Plaza Hotel, Oklahoma City.

II. INVOCATION:

Charles Atkins, MD, Oklahoma City, delivered the invocation.

III. REPORT TO THE CREDENTIALS COMMITTEE:

Ross Deputy, MD, Chairman of the Credentials Committee, announced a quorum present.

V. PRESENTATIONS:

A. AMA-ERF checks were presented to Doctor Thomas Lynn, Dean of the University of Oklahoma College of Medicine, in the amount of $22,160.74, and $2,111.00. Doctor Arnold G. Nelson, OSMA President, presented the checks to Doctor Lynn.

B. An OMPAC plaque was presented to Doctor Kent Braden, retiring Chairman of the Oklahoma Medical Political Action Committee for his outstanding service.

C. A Distinguished Service Award was given to Doctor George H. Garrison by Doctor Arnold Nelson on behalf of his efforts and fine service throughout the years.

D. A Certificate of Appreciation was presented to George Short, LL.B. by Doctor Arnold Nelson on behalf of his efforts in the passage of SB 622.

E. A Certificate of Appreciation was presented to David Bickham for his dedicated service to the OSMA. Doctor Arnold Nelson presented the award.

F. An Appreciation Plaque was presented to the OSMA by J. Hawley Wilson, Jr., of the Massachusetts Mutual Life Insurance Company (for the 20th anniversary of the OSMA Group Term Life Insurance Program).

IV. REFERENCE COMMITTEE REPORTS:

Presented By: James B. Eskridge, III, MD, Oklahoma City, Chairman.

Mr. Speaker and Members of the House of Delegates, your reference committee gave careful consideration to the items referred to it and makes the following report:

Item I: Report of the President:

Your reference committee recommends the acceptance of the Report of the President, and commends Doctor Nelson for his efforts on behalf of the Association during the past year.

Recommendations in the President's Report will be considered in reports to be presented later.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item II: Report of the President-Elect:

Mr. Speaker, your reference committee accepts the Report of the President-Elect and cites implementation of his recommendations in other parts of the report.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item III: Report of the Secretary-Treasurer:

Mr. Speaker, your reference committee reviewed the financial statement and budget for the following year of the Secretary-Treasurer's Report and recommends the approval of this report.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item IV: Board of Trustees Report and Appendix B and Supplemental Report:

The annual report of the OSMA Board of Trustees illustrates responsible activity in a variety of areas of interest during the past organizational year.

Your reference committee accepts the portion of the report concerning the public education campaign in addition to the deferment of the assessment.

Your reference committee regrets that the

Governor of Oklahoma did not appoint more than three physicians to the Board of the Health Systems Agency, Inc., despite the recommendations of the Oklahoma State Medical Association.

Your reference committee further accepts Appendix B, The Concept of the Oklahoma Utilization Review System ("OURS"), as valuable information and anticipates its implementation.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item VI: Report of the Executive Committee:

Your reference committee considered this report item by item and makes the following recommendations:

Your reference committee approves the recommendation of the Executive Committee that the House of Delegates approve the actions taken by the Executive Committee during the 1975-76 organizational year.

Further, your reference committee recommends that Recommendation No. 2 of the Executive Committee Report be deferred until consideration of amendments to the Bylaws.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item VII: Report of the Constitution and Bylaws Committee:

Your reference committee considered each item in great length and makes the following recommendations:

Your reference committee accepts the first section of the Constitution and Bylaws Committee Report dealing with necessary amendments to the bylaws to implement the recommendations of the Report of the Executive Committee.

Your reference committee believes the first paragraph of the Constitution and Bylaws Report is in error. Chapter XIII, page 30 of the Constitution and Bylaws reads as follows:

"These bylaws may be amended by majority vote of the Delegates present at any annual meeting. All amendments shall be presented in writing at one session and may be adopted only at a subsequent session. No amendment shall become effective until the close of the annual meeting at which time it is adopted."

Therefore, the prior adoption of the Board of Trustees report, containing an amendment to implement dues for Junior Members, is valid.

Finally, your reference committee recommends the adoption of Recommendations 1 and 3 in the Report of the Constitution and Bylaws Committee Report.

Your reference committee defers action on Recommendation No. 2 until consideration of the resolution involved.

Mr. Speaker, I move the adoption of this portion of the report with the exception of Recommendation No. 2. The motion was seconded and it carried.

Item VIII: Report of the Council on Insurance:

Mr. Speaker, your reference committee considered this report in its entirety. We would like to make special commendation regarding its efforts on the Qualified Retirement Trust Program and the Professional Liability Insurance Program.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item IX: Resolution No. 7:

Mr. Speaker, your reference committee considered Resolution No. 7 and makes the following amendments:

Beginning at the 4th WHEREAS to read as follows: "WHEREAS, Professional liability insurance premiums may soon become so huge as to make private practice economically impractical to many physicians in Oklahoma; and

WHEREAS, Medical cooperatives are being established as a method for furnishing defense and protection of their members; and

WHEREAS, The medical cooperative may offer a viable alternative should medical liability insurance be unavailable for any reason; Therefore be it

RESOLVED, That the President of the Oklahoma State Medical Association be directed to cause a thorough investigation of the existing medical cooperatives as well as the statutes of the State of Oklahoma relating to cooperatives . . .".

The reference committee appreciates the intent of making available an alternative plan for professional liability protection but believes that further investigation by the Council on Insurance would determine the feasibility of pursuing the final three resolves in the resolution.

Mr. Speaker, I move the adoption of the resolution. The motion was seconded and it carried.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item X: Financial Aid to Education Committee:

Mr. Speaker, the reference committee ac-

cepts with pleasure the informational report of the Financial Aid to Education Committee Report.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item XI: Report of the Physicians Committee:

Your reference committee accepts the Report of the Physicians Committee and lauds any and all efforts to inform the association members of its services.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item XII: Resolution No. 4:

Mr. Speaker, your reference committee considered Resolution No. 4 and recommends that Resolution No. 4 be tabled in favor of consideration of Resolution No. 2.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item XIII: Resolution No. 2:

Mr. Speaker, your reference committee considered this resolution at length and approves the resolution as hereby amended:

WHEREAS, it is currently the policy of the Oklahoma State Medical Association to cause mandatory membership in the American Medical Association as a condition for membership in the Oklahoma State Medical Association; and

WHEREAS, this is felt to be an arbitrary and discriminatory practice therefore be it

RESOLVED, that membership in the American Medical Association be voluntary and not a precondition or condition to Oklahoma State Medical Association membership effective January 1, 1977; and be it further

RESOLVED, that the appropriate amendments to the Constitution and Bylaws of the Oklahoma State Medical Association be enacted to accomplish this purpose, and be it further

RESOLVED, that the Oklahoma State Medical Association strongly encourage its members to voluntarily be members of the American Medical Association.

Mr. Speaker, your reference committee accepts and approves Resolution No. 2 as amended by a vote of 6 to 2.

Mr. Speaker, I move the adoption of this portion of the report.

Contingent on the acceptance of Resolution No. 2 the reference committee moves adoption of Recommendation No. 2 of the Report of the Constitution and Bylaws Committee as follows:

"Regarding the question of voluntary or required membership in the American Medical Association. If it is the desire of the House of Delegates to provide for voluntary membership in the AMA it is recommended that the amendments contained in Resolution No. 2 be adopted to properly carry out this action."

Mr. Speaker, I move the adoption of this portion of the report.

M. Joe Crosthwait, MD made the following amendment to Resolution No. 2:

"I move to amend the Report of Reference Committee No. 1, Item XIII, Resolution No. 2 by adding after the second resolve the following resolve:

"RESOLVED, That current dues paid for membership in the OSMA and AMA, remain the same in 1977 as in 1976 and that each member of OSMA be permitted, at the time of paying his dues, to indicate on the dues statement whether or not he wishes to belong to the American Medical Association, and

BE IT FURTHER RESOLVED, That the dues paid by the OSMA members who do not elect to become members of the American Medical Association shall be equitably apportioned between the county medical society and the State Medical Association on the basis of a formula to be established by the OSMA Board of Trustees."

The amendment was seconded.

The Speaker stated there is some question as to the ruling on this amendment and explained that it might be declared unconstitutional at a later date. He said, however, that nothing has been found unconstitutional at present.

Reference Committee No. 1 agreed to accept the amendment to the Report of the Reference Committee, Item XIII, Resolution No. 2.

The question was called on the amendment. With a standing vote, there were 61 "yes" and 41 "no."

After lengthy discussion, the motion and amendment carried with a standing vote of 71 to 26.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and it carried.

Mr. Speaker, as Chairman of this Reference Committee, I would like to thank the Committee members and the staff for their cooperation and work on this Committee report.

James B. Eskridge, III, MD, Chairman
Robert G. Perryman, MD
Carl H. Guild, MD
Beryl R. McCann, MD
Jack D. Honaker, MD
E. C. Yeary, MD
Royce C. McDougal, MD
Don F. Rhinehart, MD
E. N. Lubin, MD
Claude E. Lively, MD
Ronald H. White, MD
Don Blair, Staff

The House of Delegates recessed for ten minutes.

REPORT OF REFERENCE COMMITTEE NO. II:

Presented by: Jack W. Parrish, MD, Seminole

Mr. Speaker and Members of the House of Delegates, Reference Committee No. II has carefully considered the items which were referred to it and submits the following report:

Item I: Report of the Council on Continuing Medical Education:

Mr. Speaker, your Reference Committee heard considerable debate regarding the recommendations of the Council on Continuing Medical Education. The arguments for and against requiring continuing medical education as a condition for membership in OSMA are well presented in the report. Your Reference Committee recognizes that most physicians have organizational memberships that require minimum continuing education. However, the Reference Committee concurs in the opinion of the Council that it is not only within the province of a state association (comprised of members who are related to various medical components), to expect of its members some minimal continuing education standards, but also believes that such a requirement may forestall undesirable legislative action making such a requirement statutorally necessary for re-licensure or recertification. Therefore, the Reference Committee recommends the adoption of the following amended recommendations of the Council on Continuing Medical Education.

1. The Council on Continuing Medical Education be instructed to develop the criteria and necessary accompanying accreditation procedures for required continuing medical education for Association Members;

2. That the amount of required continuing medical education be evaluated in a three-year period;

3. That an official accrediting body be created by OSMA in consultation with OUHSC, the Board of Medical Examiners, the Foundation for Peer Review, Oklahoma Academy of Family Physicians and various specialty and medical organizations for the purpose of accrediting continuing medical education courses not otherwise accredited by recognized accrediting agencies;

4. That the completed plan and implementation procedures be submitted to the House of Delegates at its meeting in 1977 with the first enrollment period to commence in January 1978 and the first three-year period to conclude in December 1980;

5. That the participating organizations in Summit be commended for their fine programs and encouraged by the House to continue their cooperative arrangement.

RECOMMENDATION:

Mr. Speaker, we recommend approval of the Report of the Council on Continuing Medical Education as amended.

Mr. Speaker, I move the adoption of this portion of the report.

A motion was made to strike the word "minimum" from line 7 of Item I and the word "minimal" from line 11. The motion was seconded and it carried. The motion for the adoption of this portion of the report was seconded and it carried.

Item II: Resolution No. 3:

Mr. Speaker, in view of the position taken by the Reference Committee on the Report of the Council on Continuing Medical Education, we recommend that Resolution No. 3 not be approved.

RECOMMENDATION:

Mr. Speaker, we recommend that Resolution No. 3 not be approved.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item III: Report of the Medical Center Liaison Committee:

Mr. Speaker, the reference committee takes special cognizance of the excellent relations between OUHSC and the Oklahoma State Medical Association. Your reference committee commends the Medical Center Liaison Com-

mittee for their previous and continuing assistance to improving graduate and postgraduate medical education in Oklahoma and the OU Medical School on behalf of practicing physicians. We encourage the delegates to become familiar with the activities of the newly created Physician Manpower Training Commission and suggest that all members of the association contribute to the Health Professions Student Loan Fund created by a previous resolution of the House of Delegates, especially in view of recent publicity about the increase in tuition for medical students.

Mr. Speaker, we recommend approval of the Report of the Medical Center Liaison Committee.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item IV: Special Report of the Council on Continuing Medical Education:

Mr. Speaker, your reference committee considered the special report of the Council on Continuing Medical Education along with the report of the Medical Center Liaison Committee. The reference committee is in sympathy with the medical school's plight of being under-financed and testimony within the committee was generally supportive of OSMA providing a mechanism for financial assistance to the school. However, it is the opinion of your reference committee that there is sufficient expertise within the boundaries of the state to establish the endowment fund recommended in the special report. It is your reference committee's suggestion that the following amended recommendation of the Special Report of the Council on Continuing Medical Education be adopted:

1. The Oklahoma State Medical Association should devise a mechanism to attract contributions for an endowment to support medical education and that a complete proposal, with adequate safeguards be developed for presentation to the Board of Trustees for approval and implementation that include assurances that the funds will be equitably distributed throughout OUHSC's Medical College and Branches and that appropriate acknowledgements to OSMA be guaranteed.

Mr. Speaker, we recommend approval of the Special Report of the Council on Continuing Medical Education as amended.

Mr. Speaker, I move adoption of this portion of the report. The motion was seconded and it carried.

Item V: Report of the Council on Public Policy:

Mr. Speaker, your reference committee would like to commend the Council on Public Policy and its Chairman Joe Crosthwait, MD and OSMA's new Director of Communications, Richard Hess, for the outstanding job that they have done in the past year. Preponderance of testimony presented before your reference committee was supportive of the entire Report of the Council on Public Policy. However, in view of the recommendations of the Board of Trustees and in view of the fact that the Council was unable, due to time constraints, to present a thorough budget to the House of Delegate, it is your reference committee recommendation that the Report of the Council on Public Policy be referred to the Board of Trustees with instructions to study the public relations efforts of the association, to determine a budget to carry out those needs and to levy, when in its opinion it is necessary, an assessment of up to $100 obligatory on each OSMA member, to carry out the program developed by the Council and approved by the Board. In addition, Mr. Speaker, your reference committee would like to make it perfectly clear that your reference committee feels that Oklahoma physicians benefit, whether members of the OSMA or not, from the public relations efforts of the Council on Public Policy and therefore it is incumbent upon all physicians to contribute to this worthy effort.

Mr. Speaker, your reference committee recommends the referral of the Report of the Council on Public Policy to the Board of Trustees with instructions as stated.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item VI: Report of the State Legislative Committee:

Mr. Speaker, your reference committee decided to consider the Report of the State Legislative Committee separate from the Council on Public Policy. Your reference committee recommends that the delegates go on record as expressing a sincere gratitude to R. Barton Carl, MD, and his Legislative Committee for their outstanding services in the past year. We studied carefully the four recommendations of the Report of the State Legislative Committee and encourage delegates and the members of

the association to become more involved in the association's legislative activities. The success of SB 622 indicates that physicians when genuinely interested in legislative affairs, can produce the political influence necessary to pass constructive legislation.

Mr. Speaker, we recommend approval of the Report of the State Legislative Committee.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item VII: Supplemental Report of the Council on Public Policy:

Mr. Speaker, we recommend approval of the Supplemental Report of the Council on Public Policy. The motion was seconded and it carried.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item VIII: Resolution No. 5:

The consensus of opinion among the members of the reference committee was in sympathy with Resolution No. 5, however, since the association has previously taken a position and an AMA national health insurance is so undecided, it is the opinion of the reference committee that Resolution No. 5 be referred to the Board of Trustees for further action.

Mr. Speaker, I move that we refer Resolution No. 5 to the Board of Trustees. The motion was seconded and it carried.

A motion was made to change the last word of Item VIII to "study." The motion was seconded and it carried.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item IX: Resolution No. 6:

Mr. Speaker, your Reference Committee suggests the following editorial changes to the Resolve of Resolution No. 6:

> RESOLVED, That the Oklahoma State Medical Association go on record as opposing the Talmadge proposals WITH SPECIFIC REFERENCE TO HOSPITAL BASED PHYSICIANS and that this opposition be communicated to the members of the Oklahoma congressional delegation, to the Boards of Trustees of the American Medical Association and the American Medical Political Action Committee, and to the presidents of the College of American Pathologists, the American Society of Clinical Pathologists, the American College of Surgeons, the American College of Radiologists, the American Society of Anesthesiologists, the Council of Medical Staffs, the American Association of Physicians and Surgeons, and to the American College of Emergency Physicians, and the American College of Physical Medicine, and to the presidents of such other organizations as the President of the Oklahoma State Medical Association deems appropriate, AND TO THE AMA HOUSE OF DELEGATES BY THE OKLAHOMA REPRESENTATIVES THERETO.

Mr. Speaker, we recommend the adoption of Resolution No. 6 as amended. The motion was seconded and it carried.

A motion was made to add the American Academy of Family Physicians after the American College of Physical Medicine. The motion was seconded and it carried.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item X: Report of the Council on Professional and Intervocational Relations:

Mr. Speaker, inasmuch as this is an informational report,this reference committee recommends the adoption of the report.

Mr. Speaker, we recommend the approval of the report of the Council on Professional and Intervocational Relations. The motion was seconded and it carried.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item XI: Report of the Council on Socio*economic Activities:*

Mr. Speaker, I recommend approval of the Report of the Council on Socioeconomic Activities. The motion was seconded and it carried.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item XII: Report of the Council on Public Health and the Special Report of the Council on Public Health:

Mr. Speaker, I recommend adoption of the Report of the Council on Public Health and the Special Report of the Council on Public Health. The motion was seconded and it carried.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item XIII. Resolution No. 1:

Mr. Speaker, after considerable discussion your reference committee recognizes the necessity of providing medical expertise in the area of environmental quality and its impact upon a quality of life that reflects the high standard of medical excellence. It is our recommendation that the following substitute resolution be adopted in lieu of Resolution No. 1:

> RESOLVED, That the President of the Oklahoma State Medical Association take a leading position in the State of Oklahoma to protect the quality of environment and thereby the public health, and that a committee be appointed forthwith to study the many issues and make recommendations to the association and the public for positions on various environmental issues affecting the health of the public of our state.

Mr. Speaker, we recommend approval of this substitute resolution. The motion was seconded and it carried.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and it carried.

Mr. Speaker, as Chairman of this Reference Committee, I would like to thank the following members:
J. William McDoniel, MD, Chickasha
Joe B. Jarman, MD, Enid
Perry A. Lambird, MD, Oklahoma City
Tony G. Puckett, MD, Oklahoma City
Roger V. Haglund, MD, Tulsa
Floyd F. Miller, MD, Tulsa
T. C. Alexander, MD, Okmulgee
M. K. Braly, MD, Woodward
Kenneth L. Evans, MD, Kingfisher
Malcolm Mollison, MD, Altus
Edgar W. Young, MD, El Reno
David Bickham and Kathy Musson, staff

V. ELECTION OF OFFICERS:

The following Officers were elected:

C. S. Lewis, Jr., MD, Tulsa, was elected to the office of President-Elect.

M. Joe Crosthwait, MD, Midwest City, was elected to the office of Vice-President.

S. N. Stone, MD, Oklahoma City, was elected to the office of Speaker, House of Delegates.

Jack D. Fetzer, MD, Woodward, was elected to the office of Vice-Speaker, House of Delegates.

Harlan Thomas, MD, Tulsa, was elected to the office of AMA Delegate, Position I.

Orange M. Welborn, MD, Ada, was elected to the office of Alternate AMA Delegate.

Scott Hendren, MD, Oklahoma City, was elected to the office of AMA Delegate, Position II.

Rex E. Kenyon, MD, Oklahoma City, was elected to the office of Alternate Delegate to the AMA, Position II.

A motion was made to accept these appointments by acclamation. The motion was seconded and it carried.

VI. ELECTION OF TRUSTEES AND ALTERNATE TRUSTEES:

The following Trustees and Alternate Trustees were elected by acclamation:
Trustee District I: Craig, Delaware, Mayes, Nowata, Ottawa, Rogers & Washington Counties
Trustee: Elvin M. Amen, MD, Bartlesville
Alternate: Edward W. Allensworth, MD, Vinita
Trustee District II: Kay, Noble, Osage, Pawnee and Payne Counties
Trustee: Thomas C. Glasscock, MD, Ponca City
Alternate: Berno S. E. Ebbesson, MD, Ponca City
Trustee District III: Garfield, Grant, Kingfisher and Logan Counties
Trustee: Ray V. McIntyre, MD, Kingfisher
Alternate: Joe B. Jarman, MD, Enid
Trustee District IV: Alfalfa, Beaver, Cimarron, Dewey, Ellis, Harper, Major, Texas, Woods and Woodward Counties.
Trustee: M. K. Braly, MD, Woodward
Alternate: John X. Blender, MD, Cherokee
Trustee District V: Beckham, Blaine, Canadian, Custer & Roger Mills Counties
Trustee: F. W. Hollingsworth, MD, El Reno
Alternate: William M. Leebron, MD, Elk City
Trustee District VIII: Tulsa County
Alternate: George H. Kamp, MD, Tulsa

A motion was made to elect the trustees and alternate trustees by acclamation. The motion was seconded and it carried.

VII. ANNOUNCEMENTS:

Doctor Braden, Chairman of OMPAC, made a plea for 100% OMPAC membership and for sustaining memberships.

Doctor Fetzer announced that "Oklahoma Medical Summit" is scheduled for Oklahoma City's Lincoln Plaza Forum on May 7-8-9 and that it will present an outstanding scientific and social experience for all concerned. He stated that the principal reason for separating the business sessions from "Summit" was to permit the delegates themselves to more fully participate in the continuing education activities as well as to more fully enjoy a leisurely opportunity to visit with their professional colleagues from across the state at the many nice social functions planned for the May event.

Doctor Fetzer encouraged all the delegates to attend "Oklahoma Medical Summit" and to participate in the Professional Liability Seminar . . . a very important legal education program designed to reverse or curb the trend of growing malpractice claims against Oklahoma physicians.

VIII. ADJOURNMENT:

The 70th closing session of the House of Delegates adjourned at 12:15 p.m.

Recorded by Betty Lyles.

Report of the
PRESIDENT
April 10, 1976
(APPROVED)

Mr. Speaker, President-Elect Welborn, Members and Guests:

The past year, serving as President of the OSMA, has been a very busy one, filled with many gratifications and frustrations. The unified support from most of the membership has been phenomenal. It was truly exciting to sit in the Senate galleries with a large group of state physicians, our OSMA secretaries, OSMA executives, and many hospital administrators, and listen to the debate on our Senate Bill 622. Senator Bob Funston did a superb job of presenting and amending the bill. Finally the moment of victory in the senate came, with only one dissenting vote. The vote was 42 to 1. That, my friends, was real gratification! Only a few days ago, our bill passed the House of Representatives, again by an overwhelming majority. The vote was 88 to 3. This was gratification at its best. I have already expressed sincere appreciations to the sponsoring Senators and likewise to Representative David Riggs, Representative David Craighead and other members of the House for their cooperation and contribution to medicine by sponsoring this important piece of legislation. Many thanks go to the Legislative Committee chaired by Doctor R. Barton Carl, and our lobbyist, Mr. David Bickham. They both have worked many hours, day and night to get this bill approved, and we owe them a debt of gratitude. The membership of the OSMA rallied with a united force, and this bill sailed through our Oklahoma Legislature and I want to thank all of you so very much. Now our bill is in the hands of our Governor, the honorable David Boren. He promised he would approve the bill with his signature and it became law two days ago.

Senate Bill 622 is a good piece of legislation, but it is only a good start. We need much more, and our Legislative Committee is busy with other members of the legislature to accomplish that goal.

Many frustrations have been encountered this year in dealing with the Federal bureaucracy. We have had so many promises, many of which were broken, or delayed endlessly. Many regulations have flowed from the Washington bureaucrats, designed to control every aspect of our lives. We are fighting many of those regulations, both on a state and national level. We must stem the tide of red tape before we lose all our individual freedoms.

Our Council on Public Policy, chaired by Doctor M. Joe Crosthwait, and our Executive staff have worked all year to effect our resolution of non-participation in Utilization Review, that this House of Delegates passed one year ago. Only recently was the final draft of the document sent to HEW in Washington for approval. Our Executive Director, Mr. Don Blair, has been the real leader and work horse on our Oklahoma plan. It is our understanding that it will be approved in the very near future.

The crowning blow came from the Washington bureaucrats on New Year's Eve, when the Federal Trade Commission attorneys charged the AMA with illegally restricting competition among physicians, by not permitting advertising. We quickly came out with a policy statment in opposition to the F.T.C. Many interviews on television, radio, and newspapers were encountered. The following is a portion of the statement that I made to the press:

> "The Oklahoma State Medical Association thinks it is ironic that the Federal Trade Commission, on the eve of this bicentennial year, would want to force the medical profession to step back 100 years, into an era of hucksterism in medicine. One hundred years ago unqualified prac-

titioners preyed on the public through false advertising, and to once again encourage this would be an unfortunate step backward into the past. The OSMA considers the FTC's complaint against the AMA's ethical constraints against advertising by physicians to be totally unfounded and uncalled for."

The AMA has taken a very firm stand against the FTC. More recently the following article appeared in the February 1st, 1976, issue of Physicians Management: *"YES, F.T.C. CAN FORCE YOU TO ADVERTISE FEES.*

THAT'S WHAT FEDERAL TRADE COMMISSON ATTORNEYS TOLD US SHORTLY AFTER ISSUING THEIR COMPLAINT CHARGING AMA WITH ILLEGALLY RESTRICTING COMPETITION AMONG PHYSICIANS. AIM OF THE COMPLAINT NOW IS TO PUSH AMA INTO PERMITTING FEE ADVERTISING, NOT TO REQUIRE MD ADS. BUT FTC OFFICIALS CONTEND THEY DO HAVE *AUTHORITY* TO *FORCE PHYSICIANS TO BUY AD SPACE AT THEIR OWN EXPENSE."*

I believe our Washington bureaucrats have forgotten that we have a Bill of Rights as part of our United States Constitution. Too many of those chosen to lead us, are unable to do so, because they have been in Washington so long that they have become a part of the problem, rather than a part of the solution. The bureaucrats should quit tinkering with a free enterprise system that has given this nation the highest standard of living in the history of the world.

During the past year I have received many communications on almost every conceivable subject with which our association is concerned. I have received many letters in support of our position against the Federal Trade Commission. I have received others telling me that the Federal Trade Commission can, and will force us to advertise.

During my short experience in the private practice of medicine and during my short time of participation in organized medicine, I have learned certain lessons. In dealing with government, there *is* a time to fight. On some issues the only response must be "Never . . . this far and no further." Like murder and rape, we are all against it . . . there is no substitute for it. On other issues the more productive response is to persuade and negotiate. Most laws, regulations, and government programs are attempts to solve serious social problems. In the long run, the successful strategy is to know when to stand firm and when to compromise. It is not always enough simply to oppose ill conceived laws and regulations. It may be necessary to fashion constructive alternatives. Who knows more about how to improve health care in Oklahoma than we, as physicians?

My friends, we must stand ready to give up more of our individual freedoms, or we must stand together with the AMA against the decision of the Federal Trade Commission.

One of the important issues before our State Medical Association is our *Continuing Medical Education* program. Our Council on Continuing Medical Education, chaired by Doctor Ken Whittington, will present a detailed report at this meeting. I recommend that this House of Delegates approve that report. Whatever we do with our Continuing Medical Education Program, let's keep it under the jurisdiction and direction of our own medical association.

The *Continuing Medical Education* program in 1976 and the years to come must be one of our high priority projects.

One year ago, I recommended to this House of Delegates, a program to study the councils and committee organizational structure of our association. This study committee was to be chaired by our newly elected president-elect. This study has been carried out by President-Elect, Doctor Orange Welborn. The recommendations from that committee will be made to you today. I recommend approval of that report. I would further recommend, Mr. Speaker, that this study be continued, and that this new committee be chaired by the newly elected Vice-President. During the past year or so I have studied who should be chairman of the committee. The president-elect already has too many duties.

During the past year, your Executive Committee has been very active; likewise, the Board of Trustees has met more times than ever before. I sincerely appreciate all the work and dedicated service that the Executive Committee and Board of Trustees have put forth this year. Doctor John McIntyre has done a yeoman's job as chairman of the Board of Trustees. Last summer we had an efficiency office examination, conducted by Mr. Don Taylor, a senior Executive Vice-President of the Iowa Medical Association. One of the very strong recommendations made by Mr. Taylor was that we change the title of our Chief Ex-

ecutive Officer of the OSMA. He recommended that we change the title of the Chief Executive Officer from Executive Director to Executive Vice-President of OSMA. He also recommended that the title of the second executive in charge, be changed from Associate Executive Director, to Assistant Executive Vice-President of the OSMA, and that the other executives be titled, Assistants to the Executive Vice-President.

I have discussed this proposal extensively with our executives, with many of our members, and with other executives throughout the country. I also discussed this with Doctor James Sammons, the Executive Vice-President of the AMA. It would seem to me that this change is in order. Therefore, Mr. Speaker, I recommend to this House of Delegates that the necessary constitutional changes be written to accommodate these changes.

For the first time this year, our medical association was requested, by Dean Tom Lynn of the OU Medical School, to participate in the appointment of practicing physicians to the Admissions Board. We were directed to appoint 4 practicing physicians from each of the 6 congressional districts. We feel that the results were good both for the school as well as for the practicing physicians. We know there is room for improvement in the coming years, and changes in our appointment methods are being studied at this time.

Oklahoma Medical Political Action Committee (OMPAC) has been very active, and Chairman Kent Braden has done a great job. This is an election year, however, and there is room for improvement. The membership should be increased and the number of sustaining members should grow. We need a strong membership campaign. Every man in this House of Delegates should be a sustaining member of OMPAC. He should wear a button and Mr. Speaker, I so recommend.

The Oklahoma Medical Summit, 1976, is just around the corner. The scientific program has been completed. It appears to be the best and largest medical meeting ever to be held in Oklahoma. I would like to see every member of this House of Delegates back in this city for the Summit meeting. I want to take this opportunity to personally invite you to that meeting.

Summit Meetings in the Future. I recommend that the *Oklahoma Medical Summit* meetings for the coming years be held near the middle of September. As you know, we have commitments from the three participating organizations to continue our present joint meeting arrangement through 1979 — with their approval. I would recommend specifically that the next Summit meeting be held in Oklahoma City on September 22nd, 23rd, and 24th, 1977. Members of the House of Delegates, I bring this up for discussion.

University of Oklahoma Health Sciences Center and the *Oklahoma University Medical School.* On behalf of the OSMA, I would like to congratulate Doctor Bill Thurman, Provost OUHSC, Doctor Paul Sharp, Oklahoma University President, and the Board of Regents, for the appointment of Doctor Tom Lynn to the position of Dean. I want to express sincere appreciation to the OUHSC and the OU Medical School, for their close cooperation with the OSMA. I hope this close relationship can grow closer as the years go by. I do however, want to express one area of concern. I believe that every medical doctor at the OUHSC and the OU Medical School should be a member of the OSMA.

I want to express appreciation to *Mr. Lloyd Rader,* Director of the Department of Institutions, Social and Rehabilitative Services, for his close cooperation with the OSMA. Mr. Rader has been a power behind the scene in making our Oklahoma plan a reality.

Next, I want to thank Doctor LeRoy Carpenter, Commissioner of Health, in Oklahoma, for his assistance and cooperation from that important area of health in Oklahoma. Doctor Carpenter has been a real friend of organized medicine during my administration.

I want to express sincere appreciation to *Doctor C. Alton Brown,* for his contributions to Oklahoma medicine, for his outstanding work as Chairman of the Council on Insurance and Chairman of the Professional Liability Insurance Study Commission. He also served with expertise, with Mr. Don Blair and me on the OSMA Pension Committee, in setting up the OSMA Qualified Plan Service Company, the pension plan for the members of OSMA.

Oklahoma Foundation for Peer Review. I want to thank Doctor Hillard Denyer, President of the Oklahoma Foundation for Peer Review, and Mr. Ed Kelsay, Executive Director of OFPR, for their outstanding work in organizing the OFPR.

Peer Review Committees. I want to thank Doctor Tony Puckett, and his committees, for their many hours of hard work spent on Peer Review during the past year. Some re-

organization of the committee is being planned at this time.

I want to express sincere appreciation to all other Councils and Committees for their contributions to the OSMA this year.

I want to thank the *Woman's Auxiliary to the OSMA* for their assistance all along the way. These ladies put in many hours in our behalf, and I say thank you!

I want to publicly thank the great Governor of our State, *The Honorable David Boren,* for his assistance from the top level of Oklahoma government. His consultation and help with our professional liability legislative program, made it a lot easier. Governor Boren also appointed four new members to the Oklahoma Board of Medical Examiners. I want to thank him for his cooperation in accomplishing this important task.

I want to thank the members of the OSMA for allowing me to serve as President during the past year. It has been a tremendously rewarding year. During the year I have learned to appreciate what a tremendous Executive Staff we have in Mr. Don Blair, and Mr. David Bickham. Mr. Richard Hess is our newest executive, and he too is doing a very outstanding job. The secretarial staff has been a tremendous help. I want to extend a special thanks to Louise Martin, the Editorial Assistant of the OSMA Journal. She has been a tremendous help to me. I also want to thank the membership for their united effort, and request their continued united effort in the years to come. Without the united effort, we would not have SB 622. It is amazing to see what a powerful group OSMA really is.

Your new President will be Doctor Orange M. Welborn, Ada, Oklahoma. He is a fine man and an excellent physician. He will be an outstanding President. Please give him the kind of support that you have given me.

I want to thank my partner in practice, Doctor George R. Randels, for his kindness and consideration during my many absences from the office during the past year.

Last, but not least, I want to thank my lovely wife, Wanda, for her kindness and understanding during my very busy year as your President. Arnold G. Nelson, MD

Report of the
PRESIDENT-ELECT
(APPROVED)

Mr. Speaker, Doctor Nelson and Members of the House of Delegates:

During this past year I have watched Arnold Nelson function. He has worked tirelessly and diligently in our behalf and has given us rather dynamic leadership, and because of his leadership, we are a better Association. Arnold, we are all very grateful to you.

For me this past year has been one of appraisal of myself and of our Association. The Oklahoma State Medical Association is really a good organization, one we can be truly proud of. This past year we have solved some problems for medicine and physicians and patients. We have contained some problems. We are certainly beset by many old and new concerns and I must admit, we have ignored a few problems.

No matter what efforts or how hard we try, we shall always face challenges. Our main goal is to get these challenges in a proper perspective so that we, as an Association, can meet the issues, appraise the problems then muster our talent and resources to solve them in an orderly and business like way and with a very great unity of purpose.

We are a moderate sized medical association with relatively modest financial resources. We cannot afford to waste our efforts on trivia or unattainable goals or in petty bickering among ourselves when there are social planners in Washington, who through bureaucratic power, are trying to change medicine from a profession and an art to a tool for social reform or a public utility.

For over twenty years I have actively worked with the Oklahoma State Medical Association, either as a Trustee, general officer, council chairman or member of some of its many committees. I learned a lot about our Association. For over ten years I have been a part of the Oklahoma Delegation to the American Medical Association, and this taught me even more about the role Oklahoma plays in the national medical picture. It makes me very, very proud of Oklahoma and of our Association. This past year has added great emphasis to my pride in our State Medical Association. OSMA members have the talent and the intelligence to overcome many of our problems and God knows we have problems all around us so let's ALL work together to solve our common problems for ourselves, our Association and for our patients.

Thank you, Mr. Speaker, for the opportunity to speak to the House today.

Report of the
SECRETARY-TREASURER
April 10, 1976
(APPROVED)

The association's fiscal year ends on May 31, 1976, after which time a complete audit of the association's accounts will be conducted by the OSMA audit firm of Moak, Hunsaker and Rouse. In order to present the Delegates with the financial picture of the association at this time, it is necessary to make estimates of expenses not yet incurred for April and May, as well as to predict dues collections.

Thus far the impact of a raise in AMA dues to $250 ($140 increase) and an increase in OSMA dues to $150 ($30 increase) has not seemed to materially affect the collection rate. As of March 15, 1976, 1,413 members have paid dues this year compared to 1,128 at this time last year.

Since the OSMA collects dues on a calendar year basis, but operates on a fiscal year of June 1 through May 31, only 5/12 of new dues revenue is credited to the year ending. Next year, the total impact of the $30 dues increase should be realized, raising total dues income by about $60,000. Three new employees have been added by the Board of Trustees, as a result of a management study (and the employment of a fourth executive is planned), but a surplus in next year's operations should still be realized.

On the following two pages are the Estimated Financial Statement for the year ending and the Tentative Budget for next year (additional text begins on the bottom of the budget page).

Financial Statement

INCOME	
Dues	$230,000.00
Interest	9,000.00
AMA Commissions	3,000.00
Building Lease	4,200.00
Other Commissions	865.00
Journal Subscriptions (from dues)	8,500.00
Journal Advertising	30,000.00
Annual Meeting	3,815.40
Directory Sales	1,200.00
Student Loan (from dues)	10,000.00
Voluntary Assessment	60,589.51
Newsletter Advertising	750.00
Miscellaneous Income	1,000.00
Total Income	$362,919.91
EXPENSE	
Fixed Expenses (General Administrative)	$185,000.00
Depreciation	6,000.00
Dues Collection Commissions (Counties)	3,000.00
Councils and Committees	3,500.00
Student Loans	10,000.00
In State Travel	3,800.00
Out State Travel	22,500.00
General Newsletter	2,975.00
Malpractice Newsletter	2,300.00
Journal	42,000.00
Directory Expense (1976-77 issue)	1,000.00
Dues, Council for Health Careers	2,000.00
Other Dues	1,600.00
Expenses related to Special Assessment Purposes*	4,652.83
Total Expenses	$290,327.83
Less Special Assessment Reserves*	55,936.68
Total Estimated Surplus	$ 16,655.40

*Members voluntarily contributed $60,589.51 to a public information fund which cannot be used for general operating purposes.

Budget

INCOME	
Dues	$300,000
Interest and Commissions	12,000
Building Lease	4,200
Journal Advertising, Sales	30,000
Directory Advertising, Sales	9,000
Newsletter Advertising	2,700
Annual Meeting	3,000
Total Income	$360,900
EXPENSES	
Fixed Expenses (Administration)	$215,000
Depreciation	6,000
Council and Committee Activities	10,000
Journal	45,000
Directory	9,800
Newsletter	3,600
Student Loan Fund	10,000
In State Travel	6,000
Out State Travel	21,000
Dues, Memberships	3,500
Commissions to County Societies	3,000
Total Expenses	$332,900
Estimated Surplus	$ 28,000

The financial report estimate predicts a surplus of $16,655.40, including $3,815.40 as the OSMA share of the distribution of surplus funds remaining from the 1975 "Oklahoma Medical Summit."

The budget report estimate predicts a surplus of $28,000. A disparity in total income for this year and next, despite the dues increase, results basically from including the Special Voluntary Assessment revenue, an assessment dedicated to public information programs related to intervention in the practice of medicine. Other information about the assessment may be found in the Board of Trustees Report and in the Report of the Council on Public Policy.

As another reportable item, the Board of Trustees, acting on the recommendation of its management consultant, has voted to set aside up to 25% of each year's annual surplus as a Building Mantenance Fund. From last year's surplus of $11,468, $2,867 has been placed in a special savings account for building maintenance fund purposes.

The association's uncommitted reserves are $52,389.41, and presently reside in a certificate of deposit maturing in August at an interest rate of 5.25%.

RECOMMENDATION:

1. The association appears to be solvent for this year and the next, and no dues increase appears necessary unless indicated by the requirements of other reports to be considered by the House of Delegates.

Report of the
BOARD OF TRUSTEES
April 10, 1976
(APPROVED)

This report summarizes principal actions taken by the Board of Trustees since the last annual meeting. There have been six meetings held to date by the Trustees during the last organizational year . . . April 25th, May 4th, August 10th, October 26th, December 21st and February 29th . . a very active year for the Board. The final meeting of the Board will be on April 9th, and actions taken at that meeting will be reported in a Supplemental Report to be presented to the House of Delegates on April 10th.

Following are highlights of the actions taken during the first six meetings of the Board:

1. During the previous organizational year, the Board of Trustees had studied the implications of Public Law 93-641, "The Health Planning and Resources Development Act of 1974", as well as the course its implementation might take in Oklahoma. The law provides for the consolidation of the Regional Medical Program, the Comprehensive Health Planning Program, and the Hill-Burton Program into a single federally-sponsored program with unprecedented powers over health planning, facilities construction, manpower development and distribution, etc. Further, the law provides that management in each state could, at the option of the Governor, be delegated to nonprofit, lay-controlled "Health Systems Agencies" representing areas encompassing populations of more than 500,000 persons; or, as another option for smaller states, a single "HSA" could be established to govern health planning on a statewide basis. Your Board of Trustees elected at a meeting in March of 1975 to support the division of the state into multiple Health Systems Agencies, and individual Trustees, Officers and Staff appeared and so testified at 13 regional hearings and at a statewide "talk-back" closed circuit television hearing. Testimony presented by the OSMA and other health groups supported the multiple HSA appoach by an overwhelming (almost unanimous) majority, and 76 written recommendations for multiple HSA's were subsequently presented to the Governor representing many suggestions as to how the state should be divided into HSA districts. The issue finally resolved itself into the HSA division plan developed and advocated by the OSMA versus a plan for a statewide HSA to govern health planning in Oklahoma. However, despite the preponderance of testimony for the multiple HSA approach, the Governor elected to create a single statewide HSA in combination with six sub-area advisory councils (the advisory areas generally conform to the OSMA HSA districting plan). Governor Boren's reasons for taking this course may be summarized as follows: (1) He felt that a single HSA would permit smaller sub-area advisory regions as might be required, because the minimum 500,000 population requirement could be overcome if the statewide population was utilized as a single HSA; (2) The Governor was concerned that multiple HSA's, each having an individual contract with the federal government, could develop into an adversary rela-

tionship and lead to a federal compromise of the integrity of state boundaries and could adversely affect the sovereignty of the state; and (3) He was concerned about all relationships with the federal government that are so designed whereby state's rights may be overridden. While the Board of Trustees was disappointed in the apparent gubernatorial disregard of testimony given, his reasons for selecting the single HSA option were recognized by most Trustees to be meritorious, and after considering all aspects of maintaining a working relationship with the Governor, it was generally decided to not openly confront him with opposition on this issue. Further efforts to cooperate with the Governor's Office on implementing the Health Planning and Resources Development Act are reported in Appendix A attached to this report. The constitutionality of P. L. 93-641 is questioned by the American Medical Association and plans are underway to file a lawsuit against the federal government. OSMA Executive Director Don Blair was appointed to an advisory committee to the AMA on this subject, a committee comprised of members of the American Association of Medical Society Executives.

2. The Board of Trustees has been involved in a number of activities related to the malpractice crisis which is impacting on Oklahoma, although at this writing the two OSMA sponsored insurance programs offer our membership one of the better and more reasonably priced protection plans in the nation, relatively speaking. The Board approved the premium increase requested by the Insurance Company of North America (35%) as recommended by the OSMA Council on Insurance, and also agreed to establish an OSMA-INA trusteed "Stabilization Fund" (based on a 15% surcharge of the 1975 basic insurance premium) as an alternative to a 50% premium hike in the basic cost. In addition, the Trustees have approved the strong legislative effort being made by the OSMA State Legislative Committee to pass remedial legislation, and Trustees are appreciative of the contributory efforts made by the special Professional Liability Study Commission appointed by OSMA President Arnold G. Nelson, MD. Additional information about the malpractice situation is contained in the Report of the State Legislative Committee and in the Report of the Council on Insurance.

3. Without question the most time-consuming, complicated and perplexing issue confronting the Board of Trustees during the past year has related to the proper manner of dealing with onerous federal utilization review regulations and attempts to develop an alternate plan which would be professionally acceptable. At the 1975 annual meeting of the OSMA House of Delegates, a resolution was adopted which: (1) Expressed support for the AMA lawsuit against federal utilization review regulations issued November 29, 1974; (2) Endorsed a position of non-participation with specific respect to the November 29th regulations while, at the same time, restating a willingness on the part of the profession to continue individual hospital-based peer review and utilization review activities; (3) Authorized the Board of Trustees to institute a voluntary assessment for the purpose of carrying out an adequate public relations campaign against the regulations in question in the event the AMA lawsuit should be unsuccessful; and (4) Voted to seek a broad base of support for the campaign against the regulations by contacting other state medical associations.

Initial steps by the Board to implement the resolution are summarized along with their outcomes as described below:

a. On April 29, 1975, all state medical associations were written and their support for an all-out campaign against the regulations was solicited. Many did not reply to the letter at all, the bulk of all respondents was negative to the non-participation concept, and only a relative few state associations were in agreement with the OSMA stance.

b. At about the same time, a conference call between OSMA officers and the Executive Vice-President of the AMA and his legal staff was conducted. The AMA officials expressed confidence in the outcome of their lawsuit against the regulations and expressed concern that an all-out campaign of non-participation by the OSMA and perhaps one or two other state associations would, at that time, work to the disadvantage of the successful prosecution of the lawsuit. They specifically asked that the OSMA delay its campaign of non-participation for at least 60 days.

c. A meeting was held with Oklahoma hospital administrators during the 1975 Oklahoma Medical Summit meeting, most of whom expressed concern that a position of non-participation would bankrupt their hospitals if the withholding of federal funds should result from the campaign.

d. On April 29th, all OSMA members were advised of the non-participation resolution and

were asked to delay any implementation of the regulations in their hospitals until such time as the association could mount a campaign.

e. A public relations firm was retained, expenses were incurred in the area of ad preparation of a "general" type (in deference to the AMA request to avoid a non-participation stance during the AMA trial process), and the Board of Trustees voted to seek a $100 per member voluntary contribution to finance the campaign as it might develop. The assessment produced a total dollar response of $49,085. To this amount, the Board added $11,504.51 in residual funds left from a 1965 assessment which was earmarked by the House of Delegates for legislative purposes, making a total amount available for the campaign of $60,589.51. A breakdown of expenses properly attributable to this amount, and the residual balance, are presented as a "Note" on page 13 of this report. Those 25% or so of the OSMA members who contributed to the public information fund were recontacted and given the option to receive a refund or to rededicate their contributions to a more general public information purpose (ie. to inform the public of all manners of adverse government intervention in medical care delivery). No contributor requested a return of his or her contribution.

f. The Trustees agreed that, as a part of the public information campaign, efforts should be made to develop an alternate utilization review plan which could be reasonably operable in small hospitals (a feature totally lacking in the federal regulations of November 29th).

g. A special Executive Committee of the Council on Public Policy was asked to develop an alternate plan for hospital utilization review. The committee was composed of the following individuals: M. Joe Crosthwait, MD, Chairman; Arnold G. Nelson, MD; Kent Braden, MD; Kenneth W. Whittington, MD; and James B. Eskridge, III, MD.

h. The Executive Committee of the Council on Public Policy visited Washington, D.C. in May and met with the Oklahoma Congressional Delegation and high level officials of the federal government headed by Theodore Cooper, MD, Assistant Secretary for Health of the Department of Health, Education and Welfare. At the conclusion of the meeting, Doctor Cooper invited the OSMA to develop and submit a plan for his consideration.

The new Secretary of the Department of Health, Education and Welfare David Matthews, withdrew the controversial November 29th regulations in the process of an out-of-court settlement of the AMA lawsuit. He promised the AMA to work cooperatively in the development of new cost-control regulations. This action occurred during the process of the OSMA development of its demonstration project of an alternate plan for utilization review, and the OSMA Board of Trustees decided to continue its alternate plan course since the injunction accomplished by the AMA lawsuit affected only a few sections of the original regulations, principally the section requiring certification of the medical necessity of each hospital admission within 24 hours after the admission. To date, no new regulations have been published by DHEW, and reliable estimates are that none will be operative for a period of at least nine months, well beyond the date when a commitment must be made in Oklahoma and elsewhere across the nation regarding the establishment of plans to carry out cost and quality control under the separate Professional Standards Review Organization law.

Thus, the OSMA Board of Trustees and the Oklahoma Foundation for Peer Review face several dilemmas: (1) Whether to abandon the OSMA-designed alternative to utilization review and adopt a wait-and-see attitude regarding the forthcoming regulations (not a viable option in the opinion of the OSMA Board of Trustees since the new regulations are to be extremely delayed in their development); (2) Whether to continue the OSMA alternative plan as a proposed one-year demonstration project since it is an innovative plan felt by the Board to be cost-effective, workable in small hospitals and large hospitals alike, and designed to be more professionally acceptable than any other plan known to be in existence in the nation, or (3) Whether to convert the OSMA plan to a Conditional PSRO on July 1, 1976 and simply tolerate the confused regulatory controls which may or may not be in effect between now and the time when revised federal utilization review regulations may be available and operative.

The OSMA plan — now endorsed by the OSMA Board of Trustees, the Oklahoma Osteopathic Association, the Oklahoma Hospital Association and the Oklahoma Foundation for Peer Review — is currently in process as a federally-approvable, one-of-a-kind demon-

stration project under a special waiver application executed on our behalf by the Department of Institutions, Social and Rehabilitative Services. A summary of the plan concept and a detailed Technical Proposal are attached to this report as Appendix B. At this writing, it is not known if federal approval will be forthcoming for the one-year project to be funded and made operative. If such occurs, all present and future utilization review regulations will be waived in favor of the "Oklahoma Utilization Review System" (known as "OURS") for the period of a one-year test, after which time it would be federally evaluated as a national prototype for PSRO application. The demonstration project period would be designed to end simultaneously with PSRO planning activity now underway by the Oklahoma Foundation for Peer Review, thus making it possible to convert the project to a Conditional PSRO at the end of the test period. On the other hand, if the plan is not approved as a demonstration project for utilization review, the Board of Trustees will recommend that the application be redirected to achieve funding on July 1, 1976 as a Conditional PSRO. It may not be possible to exercise either of these two options until the April 10-11 annual meeting of the OSMA House of Delegates, due to typical federal delays in the decision-making process. However, at the end of this report will be found a generalized recommendation from the Board of Trustees that the concept be approved by the House of Delegates, and perhaps a definite sense of direction will be known by April 10-11 and the House of Delegates may share the Board's responsibility to make the final decision.

The Board of Trustees feels that its actions on this subject as reported in the preceding pages are not in conflict with the non-participation resolution adopted by the House of Delegates at its 1975 annual meeting, since the non-participation aspect of this resolution was aimed at the November 29th regulations which have now been withdrawn and are presumably being rewritten. Regarding another aspect of last year's resolution having to do with a public information campaign designed to acquaint the public with various government encroachments in the health care field, the Report of the Council on Public Policy to be considered at this annual meeting will detail past, present and projected projects to keep the public well informed as intended by those physicians who contributed to the special fund.

4. The Board approved the acceptance of a one-year $114,000 PSRO Planning Contract by the Oklahoma Foundation for Peer Review, and reluctantly accepted the resignation of Ed Kelsay from the OSMA staff to assume the job as Executive Director of the Foundation.

5. The Board of Trustees authorized the Executive Committee to conduct a management study of OSMA operations, and such has been done as reported separately in the Report of the Executive Committee to the House of Delegates. The Board of Trustees concurs in the actions taken to date by the Executive Committee in response to the recommendations of the consultant and also supports the necessary amendments to the OSMA Bylaws as recommended in the committee report.

6. To fill vacancies on the Board of Medical Examiners, the Board of Trustees authorized the President of the OSMA to submit nominees to the Governor as required by law. Harry B. Tate, MD, Oklahoma City, has replaced Donald L. Brawner, MD, Tulsa; James William McDoniel, MD, Chickasha, has replaced Thomas Parker, MD, Oklahoma City (deceased); Frank A. Clingan, MD, Tulsa, has replaced Francis R. First, MD, Checotah; and Richard L. Winters, MD, Poteau, has replaced William B. Matthey, MD, Lawton.

7. The Board authorized the Council on Insurance to develop and market a tax-deferred pension plan for all OSMA members, which has now been accomplished and will be reported in detail in the Report of the Council on Insurance at this annual meeting. Doctor Arnold G. Nelson, Doctor C. Alton Brown and Executive Director Don Blair were named by the Trustees as the Administrative Committee under the Master Trust Agreement.

8. The Trustees adopted a resolution supportive of the Medical Society of the State of New York's effort to block the plans of the federal government to code Medicare and Medicaid patients' hospital charts with the Social Security numbers of both the attending physician and the patient. It is felt that this anticipated step by the Department of Health, Education and Welfare violates the restricted use of SSA numbers to the Social Security Program and to the Internal Revenue Service. The New York group has developed a double blind coding system as an alternative which would protect the confidentiality of patient records under the PSRO program.

9. Continued financial support for the Oklahoma Council for Health Careers was approved by the Board for fiscal year 1975-76. The Council, which was the brainchild of the OSMA Woman's Auxiliary, has been very useful to the OSMA in the area of physician placement.

10. The Board approved appreciation plaques on behalf of George H. Garrison, MD, Oklahoma City; R. Barton Carl, MD, Oklahoma City; and Pam Olson, television journalist with KWTV in Oklahoma City. In addition, Doctor Garrison was selected by the Board to receive the A. H. Robins Award for Community Service. Through this report, the Board seeks approval of the House of Delegates of these awards as required by the association bylaws.

11. Trustees received a request from then Acting Dean of the University of Oklahoma College of Medicine Thomas N. Lynn, MD, for the association to endow a Faculty Chair at the College of Medicine in the amount of $750,000, the interest on which would be used to pay the salary of a distinguished professor in perpetuity. The matter was referred by the Board to the Council on Continuing Medical Education for a recommendation.

12. Trustees approved the efforts of Mr. David Bickham and the Governor's Workmen's Compensation Study Commission to develop an entirely new law which would feature various techniques to enhance objective disability impairment evaluations and compensation awards by the Industrial Court.

13. The American Medical Students Association, University of Oklahoma Chapter, received from the Board a contribution of $700 toward their annual budget and partial funding to defray expenses of two student representatives to attend the AMA Clinical Convention student business sessions.

14. Annual dues of $250 to the Oklahoma Council on Economic Education were approved. The Council supports the free enterprise system in many ways, principally through the economic education of teachers and the initiation of economic courses and teaching materials in the secondary school system.

15. A contribution of $250 in support of the Annual Essay Contest of the Governor's Committee on Employment of the Handicapped was approved by the Board.

16. Trustees endorsed the formation of an Oklahoma Chapter of the Leukemia Society of America as recommended by Raymond L. Cornelison, MD.

17. A "Find Your Doctor Day" sponsored by the Tulsa Medical Foundation and other groups was supported financially by the Board in the amount of $500 since the project was of benefit to the entire northeast quadrant of the state.

18. Thomas N. Lynn, MD, was endorsed by the Board to become permanent Dean of the OU College of Medicine, an appointment he subsequently received.

19. Life Memberships were approved for the following physicians: Franklin D. Sinclair, MD, Tulsa; M. L. Whitney, MD, Norman; Clifford A. Traverse, MD, formerly of Vian (now Oklahoma City); and Marion E. Sheets, MD, Enid.

20. The Board of Trustees reports the following breakdown of the association membership:

Active Members	2,144
Active Dues-Exempt Members	24
Applications Pending	181
Life Members	178
Affiliate Members	18
Honorary Members	0
Junior Members	163
Total Membership	2,708

RECOMMENDATIONS:

1. It is requested that the House of Delegates support and approve the actions of the Board of Trustees during the last year.

2. Regarding the "Oklahoma Utilization Review System" program as described in this report and in Appendix B, it is requested that the House of Delegates endorse the concept of the plan as developed and approved by the Board of Trustees, and that the Board be delegated the authority to implement this plan as timeliness and circumstances may dictate.

Note: Regarding income and expenses attributable to the assessment fund (page 6), the following is presented:

Assessment Income		$60,589.51
Expenses		
Ad Agency Service	$1,856.58	
Medicare Fee Rollback Folder	381.00	
Travel (Washington, D.C. . . . related to Alternate UR Plan	2,415.25	
		4,652.83
Balance		$55,936.68

APPENDIX A

Implementation of Public Law 93-641 The Health Planning and Resources Development Act of 1974

Governor Boren's plan to have Oklahoma designated as a single Health Systems Area was approved by DHEW in June 1975 after some protest by the Dallas Regional Office. Some HEW officials felt the Governor's single HSA plan violated the Congressional intent of PL 93-641, which required a minimum population base of 500,000 but set no maximum. The Governor reasoned that the state's health care system was already organized into one area and that multi-area designations would deter good planning rather than enhance it.

Having secured approval of the single area plan, the Governor proceeded to further implement the Health Planning law by appointing a Task Force on Health Systems Agency Development. The 16 member group began meeting in early August to:

1. Delineate appropriate subareas;
2. Establish relationship of subarea councils to the HSA governing boards;
3. Decide on the governing board format ie. number of members, provider-consumer representation, legal framework, articles of incorporation, and bylaws; and
4. Facilitate transition of responsibilities from health planning agencies, RMP, and Hill-Burton.

Three physicians, (2 MD's and 1 DO) served on the Task Force and members of the OSMA staff attended all but one of the planning sessions. The Task Force recommended that:

1. The state be divided into six subareas — four rural and two urban;
2. That each subarea establish a 30-member council for planning and coordinating purposes;
3. That a non-profit corporation — Oklahoma Health Systems Agency, Inc. be formed to implement the requirements of PL 93-641;
4. That a 30-member Board of Trustees be appointed by the Governor representing the six subarea councils; and
5. That the new corporation submit an application for funding to DHEW.

Upon acceptance of the Task Force report, the Governor began soliciting nominees for the subarea councils and HSA Board. Doctor Nelson, president of the OSMA, canvassed the entire state seeking physician nominees to serve on the various councils and Board. Fifty-six physicians' names were selected by Doctor Nelson after consultation with the OSMA Board, County Society Presidents and association officers. The list of nominees was presented to the Governor by the OSMA President on September 29th.

Public Law 93-641 requires that consumers compose the majority of the HSA Board, of the 30 members a minimum of 16 were to represent the public sector and a maximum of 14 providers could be selected. The definition of providers is so broad that a health insurance salesman must be considered a provider. It was anticipated that the definition of provider would preclude more than 4 to 5 physicians from being selected for service on the Board. In early October, the HSA Board appointees were announced. Three MD's, Jack Fetzer, Woodward; Galen Robbins, Oklahoma City, and George Prothro, Tulsa, and one DO, Geron Meeks, Thomas, were selected. It is anticipated that other nominees on the list will be selected to serve on the sub-area council. Doctor William Tanner, President of Oklahoma Baptist University has been selected chairman of the group. (See list attached)

One of the strong appeals made by the OSMA president was for representation on the HSA Board from the Oklahoma Foundation for Peer Review. Since the appointments did not provide a direct liaison with OFPR, the association has requested that a special committee be created consisting of physicians from the OFPR Board and the HSA Board for the purpose of advising the HSA Board on Peer Review matters. A committee has been appointed to study the request.

Health Systems Agency, Inc. has submitted an application for Conditional designation on funding to DHEW. A competing applicant, Sooner Health Congress, has also submitted an application. The principal organizer, Eric Johnson, MD, contends that the Governor has dominated the HSA Board selection process in violation of federal guidelines and seeks the designation for his non-profit corporation — HSA — OK. Principal differences in the applications are the method of selecting the various Boards and Councils and the geographic division of the state into subareas. OK-HSA proposes 11 subareas (generally conforming to the existing "B" agency boundaries) compared to HSA's six subareas. OK-HSA's Board would

consist of 30 members elected in a manner to be developed by the initial Board.

OK-HSA's application has been rejected by DHEW. It is anticipated that the Governor's plan will receive approval in early April and will be funded in June.

Health Systems Agency Board

SUBAREA I (Tulsa)
Lloyd J. Verret, Tulsa
Doctor Charles E. Christopher, Tulsa
George Prothro, MD, Tulsa
J. D. Cheek, Tulsa
Mrs. Tom Drummond, Pawhuska
Donn Dodd, Claremore

SUBAREA II (Oklahoma City)
Galen Robbins, MD, Oklahoma City
Terry Rice, Oklahoma City
Neil Towner, Oklahoma City
Mrs. John Clabes, Midwest City
George McWhirter, Mustang
Joseph Jerkins, Oklahoma City
Mrs. George L. Cross, Norman

SUBAREA III (Northeastern Oklahoma)
Dorothy Hall, Miami
Fred Hoefer, Muskogee
Jay Brown, Dewey
Ken Caughman, Tahlequah

SUBAREA IV (Southeastern Oklahoma)
Jearl Smart, Wewoka
Dr. William G. Tanner, Shawnee
Dr. James Colclazier, Seminole
Calvin Beames, Kingston
Max Minor, McAlester

SUBAREA V (Southwestern Oklahoma)
Geron W. Meeks, DO, Thomas
Peggy Risinger, Altus
Ruby McMath, Lawton
Mrs. R. H. Powell, Hollis

SUBAREA VI (Northwestern Oklahoma)
Ortho Whiteneck, II, DDS, Enid
Jack Fetzer, MD, Woodward
Laurence Drake, Gate
Mrs. W. C. Hamilton, Ponca City

HEALTH SYSTEM AGENCY

SUB-AREA DESIGNATION

SUBAREA (SAC)	POPULATION
I	516,500
II	682,400
III	339,300
IV	442,200
V	361,400
VI	320,700

APPENDIX B
(APPROVED)

The Concept Of The
Oklahoma Utilization Review System
("OURS")

Past, current and proposed federal utilization review techniques place primary emphasis on the evaluation of medical necessity and length-of-stay on a concurrent basis within the period of hospitalization. This technique is essentially designed to review patient care on a case-by-case basis rather than to assess the typical pattern of practice of the physician over an extended time period. The result is a broad focus review system which impacts identically on all physicians and which creates the following problems:

1. The system is cost and time inefficient because most physicians neither admit patients to the hospital unnecessarily nor utilize hospital services inappropriately.

2. The system is ineffective because physicians who typically practice within professionally acceptable norms are unduly distracted by frequent interventions which are largely unfruitful, and aberrant physicians can easily avert discovery through token accommodation of the system without making any meaningful changes in their patterns of practice.

3. The system does not incorporate a viable in-house incentive for the medical staff to effect permanent solutions to undesirable practice behavior problems among their number. Rather, it is a matter of each medical staff member either tolerating or accommodating the system in a manner which will leave his pattern or practice essentially undisturbed.

4. The system is as good or as bad as the medical staff of an individual hospital may make it; there is no respected outside peer group supervision to either encourage higher standards of performance or to nurture greater awareness of cost factors associated with the Medicare and Medicaid programs.

The Demonstration Project proposed would

place primary emphasis on the value of utilizing a sophisticated retrospective audit system, based on the historical performance of hospital medical staffs and individual staff members, in order to isolate typical practice behavior problems and to actuate permanent solutions through peer intervention by the Oklahoma Foundation for Peer Review, a statewide nonprofit corporation comprised of medical doctors and doctors of osteopathy which is currently under federal contract to plan for the implementation of a federal Professional Standards Review Organization in Oklahoma.

Through a system of screening discharge data elements against peer group norms, the Foundation can selectively identify potential problem institutions or problem doctors for focused review and, if indicated following subjective evaluation and consultation with the involved institution or individuals, the Foundation can impose more stringent concurrent controls on a cause-justified basis. Conversely, hospital medical staffs and individual physicians whose typical patterns of practice are found by retrospective audit to be within professionally acceptable norms can be relieved by the Foundation from compliance with much of the case-by-case review requirements presently imposed by regulations and currently required of Conditional Professional Standards Review Organizations.

Specifically, the objectives of the Demonstration Project are:

1. To establish that an objective and reliable retrospective audit system for hospital utilization review can be designed (and perfected during the one-year contract period) for the purpose of problem identification, and that statewide and/or regional peer group supervision can effectuate expeditious problem solving of a permanent nature;

2. To utilize retrospective audit to monitor the utilization performance of all state hospitals against professionally-developed norms in an effort to identify those institutions and individual physicians which either comply or fail to comply with acceptable performance standards;

3. To selectively reward institutions and individuals which meet retrospective audit standards by waiving or relaxing concurrent review requirements;

4. To selectively focus more stringent concurrent review controls on deviant institutions and individuals where warranted, and to provide assistance and encouragement to achieve waivered status through improved performance;

5. To demonstrate that the same or better end results can be obtained at less cost and with greater professional acceptance through the retrospective audit technique as compared to universal application of stringent concurrent review requirements upon all physicians and all hospitals;

6. To demonstrate that the concept embodied in this proposal is a viable, adaptable and cost-effective alternative to PSRO, and that appropriate laws and regulations should be thereby amended to accommodate programs of this type; and

7. To design the Demonstration Project in a manner which can be accurately evaluated on its relative merits as compared to traditional techniques.

(A lengthy explanation available to OSMA members on request.)

SUPPLEMENTAL REPORT
BOARD OF TRUSTEES
April 9, 1976
(APPROVED)

At the annual meeting of the Board of Trustees held at 3:30 p.m. on April 9th, the following actions were taken:

1. Doctor James B. Eskridge, III, Oklahoma City, was elected to be Chairman of the Board of Trustees for the next year, and Frank Clark, MD, Ardmore, was elected as Vice-Chairman.

2. The Board of Trustees reviewed the Report of the Council on Public Policy and after lengthy debate adopted the following motion which it wishes to transmit to the House of Delegates:

"The Board of Trustees approves the concept of the assessment recommended by the Council on Public Policy, and recommends that no action be taken at this time, but that this concept be studied, for possible implementation in the future."

3. The Board of Trustees wishes to amend the Report of the Constitution and Bylaws Committee to assess annual dues of $10 for Junior Members of the Association (Interns and Residents) as follows:

> "Amend Chapter I Section 2.051 to read as follows:
>
> "2.051 RIGHTS. They shall be entitled to all the privileges of membership, except voting and holding office. Dues may be

assessed annually by the House of Delegates."

The purpose of this amendment is to permit the association to continue mailing the Journal of the Oklahoma State Medical Association to these members in compliance with postal regulations.

4. The Board of Trustees, in accordance with the Bylaws of the Oklahoma Medical Political Action Committee, appointed the following physicians and wives to the Board of Directors of OMPAC:

Congressional District No. 1
Harold W. Calhoon, MD, Tulsa
Earl E. Smith, Jr., MD, Tulsa
Harlan Thomas, MD, Tulsa
Jack L. Richardson, MD, Tulsa

Congressional District No. 2
Elvin M. Amen, MD, Bartlesville
Ollie W. DeHart, MD, Vinita
Hillard E. Denyer, MD, Bartlesville
Tom S. Gafford, MD, Muskogee

Congressional District No. 3
Royce M. McDougal, MD, Holdenville
E. H. Shuller, MD, McAlester
Frank Clark, MD, Ardmore
Jack W. Parrish, MD, Seminole

Congressional District No. 4
Arnold G. Nelson, MD, Midwest City
Casey Truett, MD, Norman
Paul N. Vann, MD, Lawton
William Bernhardt, MD, Midwest City

Congressional District No. 5
Kent Braden, MD, Oklahoma City
Rex E. Kenyon, MD, Oklahoma City
J. R. Stacy, MD, Oklahoma City
Neil W. Woodward, MD, Oklahoma City

Congressional District No. 6
Ed L. Calhoun, MD, Beaver
William M. Leebron, MD, Elk City
E. C. Yeary, MD, Ponca City
Elaine Davis, MD, Enid

At Large
Orange Welborn, MD, Ada
(1976-77 OSMA President)
Mrs. James Haddock, Norman
(1976-77 Woman's Auxiliary President)
John T. Forsythe, MD, Tulsa
Mrs. J. R. Stacy, Oklahoma City
Mrs. Scott Hendren, Oklahoma City

5. Mark R. Johnson, MD, Oklahoma City was re-appointed by the Board of Trustees to a 3-year term as Editor-In-Chief of the Editorial Board of the *Journal of the Oklahoma State Medical Association*.

6. The Board took note of the fact that approximately 30 physicians had failed to pay the 15% surcharge on their malpractice insurance costs . . . to support a stabilization fund necessary to maintain the basic malpractice insurance program in Oklahoma. It was decided that officers of the OSMA would contact these physicians on a personal basis and attempt to collect the stabilization fund.

7. In respect to those who supported and sponsored SB 622, the Board of Trustees voted to express appreciation.

8. It has come to the attention of the Board of Trustees that a consumer group called "Oklahoma Health Security Committee" is sponsoring appearances in Oklahoma City and Tulsa on April 23rd and April 24th of Doctor Charles Mayo, an advocate of the National Health Insurance scheme sponsored by Senator Kennedy. It was decided that the Executive Committee of the OSMA should be authorized to respond to Doctor Mayo's presence in Oklahoma in an appropriate manner.

9. The following physicians were elected to Life Membership in the Oklahoma State Medical Association, based on applications received on their behalf by their county medical societies:

Oklahoma County: Hubert D. Doudna, MD; Carryl W. Wiggins, MD, J. Robert Walker, MD; S. N. Musallam, MD; Ella H. Murray, MD; R. C. Mills, MD; Sanford Matthews, MD.

Tulsa County: Donald V. Crane, MD; George M. Adams, MD; Felix P. Park, MD; Walter E. Brown, MD, John Capehart, MD, Logan A. Spann, MD.

Cookson Hills: Robert L. Currie, MD; Clifford A. Traverse, MD.

Pontotoc: William G. Peterson, MD; Frank Martin, MD

Pottawatomie: John M. Carson, MD; Charles F. Paramore, MD; Kenneth W. Navin, MD.

LeFlore-Haskell: Robert W. Lowrey, MD.

Cleveland-McClain: M. L. Whitney, MD.

Beckham: L. V. Baker, Sr., MD.

Northwest: Joe L. Duer, MD.

10. The Board of Trustees approved eight

physicians to be dues-exempt for 1976 based on fiancial hardship.

11. A 50-Year Pin was awarded to Donovan M. Mosher, MD, Seminole.

12. The dues were approved by the Board of Trustees for the American Medical Student Association, the Better Business Bureau of Central Oklahoma and the Chamber of Commerce of the United States.

13. The Board of Trustees wishes to pay special respect to Lowell H. Steen, MD and Joseph Boyle, MD, both members of the AMA Board of Trustees, who attended the entire Board session and participated in the discussions. Mr. Speaker, this concludes my report.

Report of the EXECUTIVE COMMITTEE April 10, 1976 *(APPROVED)*

The Executive Committee has met four times during the past year (at the time of preparing this report . . . an additional meeting may be held on April 9th).

At the instruction of the Board of Trustees at the 1975 annual meeting of the Board, the Executive Committee employed a management consultant to study our central office operations and to furnish recommendations related to his findings. Several management consultant firms were considered, but because of the uniqueness of professional associations and their activities it was decided to retain Mr. Don Taylor of Des Moines, Iowa, who at the time of employment had just retired as Executive Vice President of the Iowa Medical Society after 25 years of service to medicine. Mr. Taylor has been regarded as one of the top medical executives in the nation, having served as President of the American Association of Medical Society Executives in the past, and is currently national president of the Professional Convention Managers Association of America. He has had management consultant experience in the past, having been retained in recent years by the Florida Medical Association, the Medical Association of Georgia, and the Indiana State Medical Association.

Mr. Taylor obtained written reports and policy manuals from the OSMA in advance of his 3-day visit to Oklahoma City. He spent considerable time in consultation with OSMA staff personnel, both individually and collectively, and on July 19th he met jointly with the Executive Committee and OSMA staff as well as privately with the committee members only. His findings and recommendations are contained in the attached minutes of the July 19th meeting.

On August 9th, the Executive Committe met to consider the implementation of Mr. Taylor's recommendations. The following actions were taken by the committee and were subsequently supported by the Board of Trustees at its August 10th meeting:

1. *Executive Committee:* The committee concurred with Mr. Taylor's recommendation that the Executive Committee become more regularly involved in managing the association affairs by meeting on at least a bi-monthly basis. This authority is permissive in the bylaws and requires no amendments.

The committee also voted to seek Board of Trustees and House of Delegates authority to change the OSMA bylaws so that the Executive Committee could be authorized to select or approve all employees and to establish salaries and conditions of employment. The Board of Trustees as a whole presently has this authority, but has agreed to transfer it to the Executive Committee since the committee is composed of the OSMA General Officers and the Chairman of the Board of Trustees, and it is felt by all concerned that this smaller, more mobile group will become more intimately acquainted with the staff and headquarters office activities and can therefore assume these responsibilities effectively and expeditiously.

Finally, the present bylaws require the Executive Committee to report its activities to the House of Delegates, and both the committee and the Board of Trustees believe that actions of the committee should be directly reported to the Trustees. The Trustees, in turn, routinely report to the Delegates and they can include Executive Committee activities in their report as indicated. This will require a change in the bylaws.

2. Based on the consultant's observations that the OSMA was grossly understaffed in relationship to the workload, the Executive Committee, with the concurrence of the Board of Trustees, has employed Richard Hess as "Director of Information" (external and internal relations). Mr. Hess is 27 years old, possesses a Masters Degree in Journalism from the University of Oklahoma, and has had public relations work experience with the Interstate Oil Compact Commission. In addition, the Committee has employed a secretary for Mr. Hess

and a telephone switchboard operator/ receptionist, together with necessary furniture and equipment. The committee is conducting interviews to fill one more executive position, bringing our staff executive strength up from three to four persons. All of these activities are based on the consultant's recommendations and have been approved by the Board of Trustees.

3. On recommendation of Mr. Taylor, the annual business sessions of the Board of Trustees and the House of Delegates have been separated from "Oklahoma Medical Summit" for the first time. The Executive Committee recommended the separation and obtained the approval of the Board of Trustees.

4. The Executive Committee, on the advice of the consultant, has recommended to the Board of Trustees and has gained the Board's approval to create a "Building Depreciation Fund" to be financed by setting aside 25% of the annual operating surplus of the OSMA for this purpose.

5. The Committee has deferred action at this time on the balance of Mr. Taylor's recommendations such as: (1) Purchase of a 4-color press; (2) The scheduling of business meetings on days other than Sunday; (3) Improved filing and indexed reference library systems; (4) Centralized computer dues billing; (5) Taking the word "State" out of the name of the Oklahoma State Medical Association; (6) Changing titles of the OSMA staff executives; (7) The installation of a WATS line telephone service at OSMA headquarters and other matters contained in the Taylor report.

During the past year, it has come to the attention of your Executive Committee that the headquarters office has experienced a number of "hit-and-run" burglaries despite a sophisticated alarm system. At this time, cost estimates are being obtained regarding the installation of bars on certain windows in the building which are near the "marketable" items of equipment which seem to attract the burglars.

It has been recommended to the Executive Committee that the three immediate past presidents be added as voting members of the Board of Trustees. However, this matter, despite its merit, will require a Constitutional change and cannot be effected this year, so the amendments being advocated in this report by the Executive Committee with the authority of the Board of Trustees will not contain this proposed change due to the technical problem of providing 60 days' advance notice on changes affecting the Constitution.

Among other reportable actions taken by the Executive Committee during the past year was one to recommend to the OSMA Council on Continuing Medical Education that definite recommendations regarding required CME for all OSMA members be developed and transmitted to the House of Delegates at this annual meeting.

RECOMMENDATIONS:

1. That the House of Delegates approve of the actions taken by the Executive Committee during the 1975-76 organizational year.

2. That the necessary amendments to the bylaws, as recommended in this report and as approved by the Board of Trustees, be adopted by the House of Delegates (specific amendments will be detailed in the Report of the Constitution and Bylaws Committee).

Presented to: The OSMA Executive Committee on July 19, 1975

I. *ATTENDANCE:* Arnold G. Nelson, MD, OSMA President and Executive Committee Chairman; Orange M. Welborn, MD; William M. Leebron, MD; S. N. Stone, MD; Jack D. Fetzer, MD; John A. McIntyre, MD

Staff: Don Blair, Executive Director; David Bickham; Ed Kelsay; Betty Lyles.

II. *REPORT:*

Mr. Taylor prefaced his remarks by stating that the Oklahoma State Medical Association and its Executive Director were highly regarded by other Executive Directors and by the American Medical Association, and he said that the officers of the OSMA should recognize that their association was among the best in the country in terms of staff capability and productivity. From reviewing the material about the OSMA sent to him in advance by Mr. Blair prior to his July 16-19 visitation, Mr. Taylor said that there were not many areas in which he could find room for improvement, but that he had made certain notations and would commence with his findings and recommendations in major areas of concern:

A. *General:* Mr. Taylor said that the problems of medicine are so complex and so important today that a medical association must be operated in the same fashion as any business or industry, and that to do less would invite a disastrous future for physicians. A good association, he said, should have the staff capability,

the physician unity, and the financing necessary to meet a host of contemporary threats in an efficient and business like manner. As a superior objective to all other objectives, Mr. Taylor said that today an effective medical association should endeavor to become the foremost authority in its jurisdiction on all matters pertaining to professional practices and/or public health. He said it is impossible to avoid "crisis management" in such turbulent times, but that conditions should exist in any modern medical organization to generally pursue its activities in an orderly manner based on "Management By Objectives."

B. *Bylaws:* After reviewing the OSMA Constitution and Bylaws, Mr. Taylor said that the OSMA Executive Committee should be given broader authority to govern the day-to-day activities of the association, including the employment of personnel and the establishment of salary scales. In Iowa, he said, the counterpart organization to the OSMA Board of Trustees is the Council, which meets four times a year to handle judicial questions and policy matters consistent with House of Delegates policies. However, the IMS has an 8-man Board of Trustees which is an arm of the Council similar in its function to the Executive Committee of the OSMA. The IMS Board meets monthly to manage the ongoing affairs of IMS, and the doctors serving on this Board become intimately acquainted with operations and with staff capability to such an extent that they also have the authority to establish salaries and conditions of employment.

He said it would take minor changes, if any, in the OSMA bylaws in order to establish the OSMA Executive Committee in the same manner as the Board of Trustees is functioning in IMS, and he so recommended that such changes be instituted in the interest of more physician involvement in the management process.

He added that this close working liaison between the top Executive officer and other members of the OSMA staff in relationship to the members of the OSMA Executive Committee would provide for improved communications and for a general feeling of security and sense-of-purpose among the staff members.

In connection with staff relations, Mr. Taylor said that he had the authority from his Board of Trustees to act unilaterally to resolve staff problems; moreover, he emphasized the importance of loyalty to the association and to the Executive Director on the part of all staff employees, and that he would not tolerate conduct of a disloyal nature or other conduct which bred disharmony within the IMS staff.

C. *Staff:* The consultant said it was quite obvious to him that the OSMA was understaffed in view of the volume of work being produced; in fact, he said the productive capacity of the 8-person OSMA staff was comparable to the output of the IMS staff of 13 full-time employees and 6 part-time fieldmen (75% paid by Iowa Blue Shield and more than 50% controlled by Iowa Medical Society). He reported to the Executive Committee that he had four executives on his staff and two other persons who had executive functions of a secondary nature.

Specifically, Mr. Taylor identified an OSMA vacuum in the area of public information. He recommended very strongly that the association hire a full-time journalist with concomitant skills in the areas of layout and printing. This person would have no duties other than internal relations, external public information activities, editorial management of the Journal and the production of other internal printed materials. He pointed out that interviews with OSMA staff personnel indicated that Mr. Kelsay's time had been diluted to the point where only 10% of his efforts were being devoted to matters of public information, and he emphasized the absolute necessity to have a continuous effort being made by a staff specialist to initiate communications of all sorts and to respond immediately to new situations as they develop without appreciable lag time. At IMS, he said, they have such a person who not only creates copy for internal and external consumption but also operates a three-color press and produces the bulk of all internal communications on an in-house basis. Mr. Taylor distributed samples of the in-house printing produced by his association and his staff journalist-printer. In this connection, he strongly suggested that our association explore the possibility of purchasing the necessary printing equipment to improve the quality and the frequency of internal communications, and once again re-emphasized the necessity of employing a public information director with multiple skills in order that the expensive equipment could be efficiently utilized on a frequent basis.

D. *Organization:* Regarding operational departments of a typical medical association, Mr. Taylor said that most associations are doing about the same thing . . . there are major departments in the areas of socioeconomic ac-

tivities, legislation, governmental relations, scientific activities and public information.

As an example of how staff personnel could be assigned to major activities, in this instance perhaps a "Council on Socioeconomic Activities and Governmental Relations," he mentioned that the association lobbyist could work within this framework and assume responsibility for all legislative activities, all relationships with government agencies and bureaus, all relationships with third party carriers, etc.

He said there was nothing magic about organization . . . the priorities are obvious, and the association must simply gather together the necessary staff talents and harness them to organizational departments so that priority, high-stakes objectives can be dealt with effectively.

Taylor cautioned the committee members not to delude themselves into thinking that they had many allies left . . . he expressed concern about the motives of hospital associations, the pharmacists, the nurses, Blue Cross/Blue Shield, and other groups once thought to be medicine's allies but who now seem to be working at cross purposes. In short, he said, the medical association must be prepared to go it alone, and must develop the necessary strength to control other so-called allies in the health field if it hopes to deal effectively with the threat of a government takeover of the profession. If these health-related groups can't be beaten by medicine, he said, then we must at least try to romance them into some sort of unified front because a fragmented approach is ineffective.

Mr. Taylor said it would be an extremely good idea if the OSMA Executive Director would hold regularly-scheduled weekly meetings with his Associate Executive Directors in order to assess past performances and to establish work objectives for the following week. He said these staff conferences should be changed or altered only rarely, and should be formalized so that one such meeting occurs on a weekly basis. In addition, he said it is a good idea, as well, to hold periodic meetings of the entire association staff in order that all employees are generally acquainted with the ongoing activities and objectives of the association. In the case of IMS, he said, such general staff conferences are held about four times a year.

The OSMA practice of holding most Council and committee meetings on Sundays was questioned by Mr. Taylor. He said that not only physicians need to attend church on Sunday and use this day to otherwise be with their families, but such practices are also beneficial to the staff. In Iowa, he said, a number of years ago a strong president of their association decreed that no more meetings would be held on Sunday with the possible exception of House of Delegates. He said it was surprising how easy it was to condition the physicians of Iowa to attend important Council and committee meetings on Wednesdays and Thursdays . . . many of whom enjoy the opportunity to leave their practice and bring their wives and families to Des Moines for shopping and various entertainment pursuits. He said he had information that the OSMA staff is involved in about 25 Sunday meetings a year, and observed that most of these could be avoided by a change in the OSMA meeting policy. He also mentioned the payment of overtime or getting compensatory time off for staff persons who might have to work on week ends or after hours.

Another idea advanced by Mr. Taylor regarding OSMA organization was his suggestion to separate the annual scientific program (Oklahoma Medical Summit) from the annual meeting of the House of Delegates.

E. *Finances:* The consultant reported medical association dues in Iowa are $200 a year, and that he had noticed that present OSMA dues of $120 will be increased to $150 in January; further, he noted that the association just concluded an organization year with a balance slightly more than $10,000. He said that the $30 increase should generate sufficient new revenue to improve staff capability and to set aside additional reserves. In discussing reserves, Mr. Taylor noted that the OSMA accountant is not depreciating the building because it is not necessary for tax purposes. However, he said it would be a good idea to establish a reserve fund for the building in order to build a reservoir over the years to take care of repairs and general maintenance.

Regarding salaries, Mr. Taylor said the rule-of-thumb for associations of all types is to spend less than 50% of the annual budget on staff salaries, and he said his review of the OSMA financial statement indicated that the OSMA was well below the 50% figure.

F. *Miscellaneous:* Mr. Taylor said that several OSMA employees had mentioned a prob-

lem in answering more than 100 telephone calls a day. Presently, he said, one employee was responsible for a one-week stint in being the primary receiver of incoming calls, with other secretarial staffers serving as backup for handling multiple calls on the three incoming lines of the OSMA. This practice, he said, was disruptive of other office routines and some solution should be sought by the Executive Committee such as the employment of a full-time telephone operator/receptionist.

In the area of filing, Mr. Taylor said there was no good solution to the many filing problems encountered by a typical medical association dealing with a variety of subjects and voluminous correspondence. Regardless of the system employed, he said, a principal area of concern should be to hold all persons responsible for filing to be thoroughly accountable for proper filing. He said it would be a good idea to make certain that all employees are thoroughly acquainted with the existing filing system and that periodic refreshers should be conducted due to personnel changeover.

As another time-saving technique which the OSMA could employ, Mr. Taylor suggested investigation of computerized central billing on county, state and AMA dues. He said such had been done in Iowa and had resulted in a much more effective operation; Taylor promised to have his computer company contact Mr. Blair regarding the details and costs of this service. In addition, he suggested that the association bank be authorized to computerize the payroll and issue checks each month, not only to save OSMA staff time but to provide the OSMA payroll security.

The open meeting adjourned at 3:25 p.m. and was followed by an Executive Session.

Report of the CONSTITUTION AND BYLAWS COMMITTEE
April 10, 1976
(APPROVED)

Committee Members

Lewis C. Taylor, MD, Chairman, Oklahoma City
Floyd F. Miller, MD, Tulsa
Richard Wade, MD, Midwest City
Bob J. Rutledge, MD, Oklahoma City
Jerold D. Kethley, MD, Shawnee
George Garrison, MD, Oklahoma City

The OSMA Constitution and Bylaws provides that all amendments proposed must be routed through the committee prior to consideration for adoption by the House of Delegates.

The following items have been identified in the business proceedings of this meeting as requiring amendments to the bylaws:

1. *Report of the Executive Committee:* The Executive Committee has recommended and the Board of Trustees has concurred that the committee's scope of activities be expanded to transfer to it the Board of Trustees authority to select or approve all employees and to establish salaries and conditions of employment. Moreover, the Executive Committee feels that it should be responsible to report annually to the Board of Trustees rather than the present requirement to report to the House of Delegates.

To accomplish these changes, the Constitution and Bylaws Committee recommends the following amendments to the bylaws:

(a) *Replace Section 7.06 of Chapter V of the Bylaws to read as follows: "7.06 CENTRAL OFFICE. The Board of Trustees shall establish and maintain a central office." (Deletes reference to employees).*

(b) *Amend Section 5.01 of Chapter X of the Bylaws by replacing the next to the last sentence with the following sentence: "It shall report all of its official actions to the Board of Trustees at the next regular meeting of the Board."* (Changes reporting procedure.)

(c) *Amend Section 5.01 of Chapter X of the Bylaws by inserting the following sentence between the last two sentences of the section: "It shall select or approve all employees of the association and shall establish salaries and conditions of employment."* (Transfers authority regarding employees from Board to Committee).

2. *Resolutions Numbers 2 and 4:* These resolutions seek to change the Bylaws in order that membership in the American Medical Association be made voluntary rather than required. As in the past when this issue has been considered by the House of Delegates, the Constitution and Bylaws Committee has taken no position on the subject, but has simply commented on what amendments to the Bylaws would be necessary to make this change if the Delegates desire to do so.

Resolution 4 does not contain specific recommendations regarding the nature and language of the amendments necessary to carry

out its intent, while Resolution 2 provides for specific amendments.

The Constitution and Bylaws Committee has checked the proposed amendments presented at the end of Resolution 2 and recommends that they be utilized to accomplish the purpose set forth in both resolutions if it is the will of the House of Delegates to provide for voluntary membership in the AMA.

3. *Report of the President-Elect:* The President-Elect, Doctor Welborn, has included in his message to the House of Delegates certain recommendations involving the organizational structure of the association (he did so at the request of outgoing President Nelson). Doctor Welborn's stated purposes in requesting changes in the Council structure are to clarify the nomenclature of the Council designations, to set forth in general terms the job descriptions of the redefined Councils, to eliminate oversights in providing Council coverage for all broad jurisdictions in which the association is involved, to consolidate certain activities now handled by Standing and Special Committees and transferring their duties to appropriate Councils, and to place emphasis during his term of office on utilizing the revised Council structure so that virtually all program activities will be under the assigned management responsibility of seven Councils. As will be explained later in this report, the Chairmen of Councils will serve as principal advisors to him in overall OSMA management through their automatic membership on the new Council on Planning and Development.

The Constitution and Bylaws Committee supports the intent of Doctor Welborn's proposal . . . it should streamline and clarify association management practices . . . it will place emphasis on the team approach to problem-solving . . . it will delegate the growing multiplicity of OSMA activities to a secondary level of managers (Council Chairmen) . . . and it will provide a more orderly process for developing long range and annual program priorities. At the same time, it will not concentrate power in the hands of a few as no less than 65 physicians will be members of Councils, and 4 Standing Committees will be retained. Moreover, the appointment of Special Committees will still be utilized on highly specialized or time-consuming projects.

In preparing and presenting amendments to the bylaws necessary to carry out the President-Elect's recommendations, the changes will be delineated in this report by first establishing the new Councils . . . by secondly proposing another set of amendments necessary to knit the new system together . . . and, thirdly by summarizing the important new features of the system.

(a) *Amend Chapter IX of the Bylaws by striking it in its entirety.* (To delete the previous Council system).

(b) *Create a new Chapter IX of the Bylaws, entitled "Councils" as follows:*

"Section 1.00 COUNCILS. The Councils of the Association shall be: Council on Planning and Development, Council on Members Services, Council on Medical Service, Council on Professional and Public Relations, Council on Governmental Activities, Council on Medical Education, and Council on Public and Mental Health.

"Section 1.01 PURPOSE. The Councils shall assist the President in the planning and conduct, supervision and control of appropriate aspects of association activities. At the discretion of the President, association Standing Committees and Special Committees may be grouped under the direction of appropriate Councils.

"Section 1.02 APPOINTMENT. The Council on Planning and Development shall be chaired by the Immediate Past President, and shall otherwise consist of the President, the President-Elect, the Speaker of the House of Delegates, the Chairman of the Board of Trustees, the Chairmen of all other association Councils, and Delegates and Alternate Delegates to the American Medical Association. Other Councils, as identified in succeeding sections of this chapter shall be appointed annually by the President and shall consist of no less than nine members of the association. The membership of each Council may include the chairmen of the committees under its direction. Except for the Council on Planning and Development, appointments shall be based on staggered tenures of three years each.

"Section 2.00 COUNCIL ON PLANNING AND DEVELOPMENT.

"Section 2.01 DUTIES. The Council will study and make recommendations to the Board of Trustees and to the House of Delegates concerning the long-range objectives of the Association, and will assess

and make recommendations regarding the resources and programs necessary to reach these objectives. It will also present at each annual meeting its recommendations to the Board of Trustees regarding an Annual Program of Activities which must be consonant with long-range planning objectives.

"Section 3.00 COUNCIL ON MEMBERS SERVICES.

"Section 3.01 DUTIES. The Council will assume responsibility to plan and carry out services of all types having direct benefit to association members and constituent county or district medical societies of the association, including but not limited to insurance benefit programs, special publications, travel programs, services to the Woman's Auxiliary, student and house staff relations, speakers services, membership surveys, personal services including counselling, membership recruitment, and adjudication of disputes. The activities of the Council shall be governed by the association's Annual Program of Activities as determined and interpreted by the Board of Trustees.

"Section 4.00 COUNCIL ON MEDICAL SERVICE.

"Section 4.01 DUTIES. The Council will study, make decisions and formulate activities with respect to the provision of adequate medical care, including but not limited to the design or evaluation of all types of health care delivery systems, health planning, the financing of medical services and its impact on the quality of patient care, the social aspects of health, internal peer review mechanisms and the appraisal of all external programs which affect the cost or quality of medical care. The activities of the Council shall be governed by the association's Annual Program of Activities as determined and interpreted by the Board of Trustees.

"Section 5.00 COUNCIL ON PROFESSIONAL AND PUBLIC RELATIONS.

"Section 5.01 DUTIES. The Council shall plan and conduct all activities of the association with respect to public relations and public service projects, interprofessional and intraprofessional relations, all in cooperation with other Councils and Committees of the association. The activities of the Council shall be governed by the association's Annual Program of Activities as determined and interpreted by the Board of Trustees.

"Section 6.00 COUNCIL ON GOVERNMENTAL ACTIVITIES.

"Section 6.01 DUTIES. The Council shall review Federal and State legislation and regulations of concern to the medical profession or the public health, and shall initiate activities or undertake appropriate responses on matters of priority interest. It shall also establish and maintain regulations with Federal and State government entities having statutory or regulatory jurisdiction affecting the medical profession, the delivery of health care, or the public health. In cooperation with other association Councils and Committees, it shall communicate with the medical profession, it shall develop policy recommendations for consideration by the Board of Trustees, and it shall prepare testimony and otherwise conduct the legislative program of the association. The activities of the Council shall be governed by the association's Annual Program of Activities as determined and interpreted by the Board of Trustees.

"Section 7.00 COUNCIL ON MEDICAL EDUCATION.

"Section 7.01 DUTIES. The Council shall study and make recommendations related to all matters of maintaining or improving the level of medical competency in Oklahoma, including but not limited to maintaining liaison with medical education colleges in Oklahoma, to maintaining liaison with other health professions and occupations, to the continuing assessment of emerging health professions or occupations, to conducting continuing medical education courses for association members, to the accreditation of medical education programs in Oklahoma. It will also monitor continuing medical education standards as they may be required by association policy. Financial aid to education shall also be among the duties of this Council. The activities of the Council shall be governed by the association's Annual Program of Activities as determined and interpreted by the Board of Trustees.

"Section 7.012 SCIENTIFIC ASSEMBLY. The Council on Medical Education, with the approval of the Board of Trustees, may work with other interested medical and allied health organizations to arrange for joint meetings of a scientific and medical nature. It shall be responsible for assisting in the planning, conduct and publicity of such programs, and for the planning and conduct of other related events and functions not otherwise assigned to other association committees and officers.

"Section 8.00 COUNCIL ON PUBLIC AND MENTAL HEALTH.

"Section 8.01 DUTIES. The Council will represent the association in all matters related to public or mental health, including but not limited to maintaining effective liaison with public or private organizations engaged in activities of this type, and the sponsorship of programs for the betterment of public or mental health, either singularly or in cooperation with public or private agencies having similar interests. The activities of the Council shall be governed by the association's Annual Program of Activities as determined and interpreted by the Board of Trustees."

Amendments supportive of the foregoing amendatory descriptions of the seven new Councils are as follows:

(a) Amend Chapter V, Section 8.00 of the Bylaws by substituting the following section:

> *"Section 8.00 ADMINISTRATION AND ANNUAL PROGRAM OF ACTIVITIES. The Board of Trustees shall adopt administrative rules of procedure necessary to carry out the duties herein described, and shall develop an Annual Program of Activities based on recommendations submitted by the Council on Planning and Development. The program of priority projects shall be considered and developed at the annual meeting of the Board of Trustees for implementation during the succeeding organizational year."*

(Provides authority to the Board to establish an "Annual Program of Activities").

(b) *Amend Chapter X, Section 1.00 of the Bylaws by striking the words "Scientific Assembly Committee".* (Function is now a duty of the Council on Medical Education).

(c) *Amend Chapter X, Sections 2.00 and 2.01 by deleting them in their entireties, and by properly re-numbering succeeding sections.* (Function of Scientific Assembly is now a duty of the Council on Medical Education).

(d) *Amend Chapter X, Sections 4.00 and 4.01 by deleting them in their entireties, and by properly re-numbering succeeding sections.* (Function has now been transferred to the Council on Medical Education).

(e) *Amend Chapter X, Sections 6.00, 6.01 and 6.02 by deleting them in their entireties, and by properly re-numbering succeeding sections.* (Present Committee on Planning has been moved to Council status as "Council on Planning and Development").

The net effect of the foregoing amendments is to create seven newly-named Councils, to provide job descriptions for each, to formalize the authority of the Board of Trustees to establish an Annual Program of Activities, and to eliminate as Standing Committees the Scientific Assembly Committee, the Medical Center Liaison Committee, and the Committee on Planning . . . all of whose duties have been transferred to Council status.

RECOMMENDATIONS:

It is recommended that the amendments to the Bylaws related to new functions and activities of the Executive Committee be adopted by the House of Delegates.

2. Regarding the question of voluntary or required membership in the American Medical Association, if it is the desire of the House of Delegates to provide for voluntary membership in the AMA it is recommended that the amendments contained in Resolution No. 2 be adopted to properly carry out this action.

3. It is recommended that the amendments set forth in the third section of this report be adopted to change the organizational structure of the association as requested by the President-Elect.

Report of the
COUNCIL ON INSURANCE
April 10, 1976
(APPROVED)

C. Alton Brown, MD, Chairman, Oklahoma City
C. E. Woodard, MD, Tulsa
Robert A. Nelson, MD, Tulsa
Virgil Ray Forester, MD, Oklahoma City
Robert W. Kahn, MD, Oklahoma City
Glen L. Berkenbile, MD, Muskogee
Jack Berry, MD, Okarche
William M. Leebron, MD, Elk City
Howard Bennett, MD, Bartlesville
William G. Bernhardt, MD, Midwest City
Thomas C. Glasscock, MD, Ponca City

SECTION I

Qualified Retirement Trust Program

The Board of Trustees instructed the Council on Insurance to develop a qualified retirement program for association members following a 1975 survey which revealed a desire on the part of the membership for the OSMA to furnish a plan of this type.

The Council was assisted by the association's legal counsel (Lytle, Soule and Emery) and by the OSMA accounting firm (Moak, Hunsaker and Rouse) in creating a Master Retirement Trust which is flexible enough to provide all members, whether incorporated or not, with a variety of options to design a plan specifically tailored to their individual needs and goals.

The program will be overseen by the OSMA Pension Committee, which is comprised of the Chairman of the Council on Insurance, another physician who is selected annually by the OSMA Board of Trustees, and the association's Executive Director. Presently, these individuals are C. Alton Brown, MD, Arnold G. Nelson, MD, and Don Blair.

Program management has been delegated to a new company created especially for this purpose . . . "OSMA Qualified Plan Service Company." The principals of this company are J. Hawley Wilson, Jr., Robert J. Bell and Robert A. Cortright, all Chartered Life Underwriters. Investments will be managed by the First National Bank and Trust Company under the leadership of C. Randolph Everest, Executive Vice-President and Senior Trust Officer of the bank.

The OSMA plan offers many unique advantages to Oklahoma physicians who seek a convenient and reliable system to set aside tax-deferred dollars today for their future retirement needs. Some of the advantages of the program are:

- Savings in start-up costs as compared to other plans.
- Savings in year-to-year operational costs such as administrative fees.
- Trustee fees, legal expenses, actuarial services and accounting services.
- Investment diversification through the substantial pooled trusts of the First National Bank.
- Options to accommodate the individual needs and circumstances of all physicians, whether they may be professional corporations, solo practitioners or unincorporated partnerships. The funds may be invested totally in fixed income accounts or totally in equity accounts, or in a balance between fixed income and equity accounts.
- Insurance may be included in the plan as an option available to the employer doctor. The Massachusetts Mutual Life Insurance Company will be utilized for this purpose.
- The plan will be locally serviced by a management team possessing diversified skills and long-term experience in the pension field.

A folder on the program has been mailed to all OSMA members and, to date three association members have entered the program and 53 others have requested individual counselling and are considered good prospects.

SECTION II

Professional Liability Insurance

Of supreme concern to the OSMA and to the medical profession nationally is the preservation of a professional liability insurance market at premiums which physicians (and their patients) can afford to pay.

The situation nationally is chaotic, with some physicians paying close to $40,000 annually for adequate protection, and others unable to buy insurance at any price. In 1975, some 40,000 malpractice claims were made against physicians nationally . . . the proliferation of claims (up 225% in five years) and the doubling of the size of awards has caused most of the malpractice insurance carriers to quit the market. Only about ten insurance companies are still in the market nationally, and of these only about five are doing any significant amount of business. In the "umbrella", or excess limits market, matters are even worse, with only three or four carriers continuing to operate.

It is paradoxical that we are experiencing this surge in liability actions at a time when the competency of physicians has never been higher. All manner of legislation is being passed by state legislatures across the nation, but while such legislation may be helpful in the defense of claims, there seems to be no relief in sight to change the nature of an increasingly litigation-minded society. Moreover, liberal judges and juries are often holding physicians liable for the outcome of care with little regard for proof of negligence.

Here in Oklahoma we still have one of the better professional liability climates and in-

surance programs in the nation, but there is no question that the situation is worsening . . . the frequency of claims against Oklahoma physicians is increasing and the amounts of awards are likewise on the upswing.

The OSMA was the first state in the nation to have a sponsored malpractice program, and the large underwriting base developed under this concept over the years has undoubtedly been of benefit in holding on to a reasonably stable insurance market.

In 1976, however, the premium rates for the basic coverage ($100,000 protection) provided to the OSMA by the Insurance Company of North America were increased 35%, and we found it necessary to add another 15% surcharge to create a "Stabilization Fund." This fund, jointly trusteed by the association and the INA, will eventually generate $500,000 which can be utilized for claims settlements if the INA is forced to leave the market in Oklahoma for any of three causes: (1) State or federal legislation which would force INA's withdrawal; (2) OSMA cancellation of INA sponsorship; (3) Two consecutive unprofitable years as calculated by actuarial standards in common use throughout the insurance industry. Claims could be paid from the fund only for a period of seven years after the last policy expired, at which time residual funds in the account would revert back to OSMA ownership to be used only "for purposes related to professional liability."

Ratewise, despite the overall 50% increase in the cost of the basic INA plan, the OSMA continues to enjoy one of the lowest-priced high quality programs in America. As awards and claims frequency increase, however, we can expect insurance costs to be raised accordingly.

The OSMA umbrella plan is written by the Continental National American (CNA), and we have not been so fortunate in maintaining a reasonable premium in this area, principally because it is rated by national loss experience in contrast to the state experience rating system employed by the INA. At least one other carrier has expressed an interest in bidding on the OSMA umbrella prior to its next renewal. Unfortunately, in recent months we have suffered several substantial losses against the umbrella plan, and should this loss pattern continue it could compromise our ability to find relief from the more than 300% premium hike we have suffered this year.

Everything possible is being done by various elements of the OSMA to stabilize the situation.

OSMA President Arnold G. Nelson, MD, appointed a special Professional Liability Study Commission, and this group has worked closely with the Council on Insurance and with the State Legislative Committee in developing legislation which, at this writing, holds promise of becoming law and providing some measure of relief (see Report of the State Legislative Committee). One feature of this bill (Senate Bill 622) could materially stabilize the OSMA insurance program . . . a section of the bill which would set the statute of limitations at a maximum of 3 years. Presently, liability exposure is infinite in medical practice since the present 2-year statute does not toll until the patient "discovers" an alleged injury.

Another preventive effort will be made at "Oklahoma Medical Summit" next month when an afternoon-long program will be conducted by OSMA defense attorneys to teach physicians more about the legal responsibilities they have to the patients they serve. The special course will be inaugurated at the Summit meeting but will be repeated several additional times throughout the year.

Present total professional liability premium costs for OSMA members approach $4 million, and this is likely to increase if the adverse trend in claims continues.

Your Council on Insurance is well aware of the responsibility it shoulders in trying to curb rising costs and in the prevention of a total collapse in insurance availability. In our defense, however, it is no accident that our members today enjoy such a relatively favorable place in the national picture. Our association has been more involved in the day-to-day management of our program than any other state association, and the payoff can be seen today in the favorable position we enjoy.

All OSMA members can help by learning as much as they can about their legal responsibilities . . . by continuing or increasing their postgraduate education activities . . . by keeping accurate and complete medical records . . . by enhancing their personal rapport with all patients served . . . by promptly reporting to the INA any threatened claims . . . and by being constantly aware of the malpractice problem as you practice your profession each day. Professional competence, courtesy, thoroughness, and attentiveness in all of your professional affairs will do more than all of the

legislative efforts in the world to forestall the filing of malpractice actions or in paving the way.

SECTION III
Group Term Life Insurance

The life insurance program is underwritten by the Massachusetts Mutual Life Insurance Company through the Wilson Insurance Agency in Oklahoma City.

Since it began in 1956, about $1,000,000 in death benefits have been paid to the survivors of OSMA members.

There are 244 association members presently insured at an annual premium cost of $57,783.90. However, the billings now in process for the current policy year will be offset by dividend credits of $5,200.55, reducing the net total premium due to $52,583.35. This represents a 9% premium reduction for the current year.

Efforts are being made to extend the program to medical students who are eligible for the plan if they simply take advantage of the dues-free association membership which is available to them. A student under age 30 can purchase $50,000 protection for only $100 a year.

In addition, for the first time this year, changes in the plan have been made to make the program available to physicians' employees on the following schedule:

- Administrative Assistants . . . $20,000 in coverage is available (definition covers employees earning $8,000 or more).
- Medical Assistants . . . $8,000 in coverage is available.
- Clerical Personnel . . . $4,000 in coverage is available.

This valuable fringe benefit may be made available by OSMA members to their employees at minimal cost, either paid totally by the doctor or on a contributory basis. Premiums are deductible.

Physicians may purchase up to $50,000 coverage for themselves (death from natural causes) and are protected by a $250,000 death benefit for accidental death on a common carrier. The policy is not only competitively priced, but includes such unusual features as dismemberment and loss of sight benefits, waiver of premium if disabled, and private flying coverage.

Premiums are deductible for incorporated physicians.

With the sales effort to be made in the program this year . . . with the new eligibles added through amendments to the program . . . and with the natural tie-in with the new OSMA Qualified Retirement Program . . . enrollment in the plan should greatly increase in the months and years ahead.

SECTION IV
Disability Income Insurance

The OSMA disability program is underwritten by the Washington National Insurance Company through C. L. Frates and Company, Oklahoma City.

There are 500 OSMA members protected by this excellent program at a total annual premium of $168,248. Claims paid during the last year were $69,583. During the past three years, 1972 through 1975, total premiums were $508,405 and total claims paid were $170,958. Outstanding reserves are $83,025 and incurred losses are $253,983. An approximate loss ratio of 50% (earned premium to incurred loss) places the program on an even keel, and a reduction in the average age of the insured group promises stability in the program.

Benefit-wise, the plan offers a number of options to meet most physicians' needs: up to $2,500 a month indemnity, waiting periods from 7 days to 1 year, payment periods on benefits range from 5 years or to age 65, a lifetime benefit period is standard for disability due to accident, and a $5,000 death or dismemberment benefit.

SECTION V
Overhead Expense Insurance

This program is underwritten by the Continental Casualty Insurance Company through C. L. Frates, Oklahoma City.

The tax-deductible program indemnifies a doctor against the cost of keeping his office open during periods of disability . . . up to $3,500 a month in benefits may be obtained, with a benefit payment period covering disabilities of 18 months' duration.

Presently, there are only 174 OSMA members insured at a total premium of $29,159. Claims have been minimal ($13,333) but when added to reserves of $8,019, a loss ratio of 73% is produced.

It is felt that this program will become more popular in the future since there is a trend to-

ward limiting the amount of disability income protection a doctor can buy, and the OSMA Overhead Expense Plan offers an opportunity to extend the amount of protection available.

SECTION VI
Major Medical/Hospital Insurance

This plan is underwritten by the Washington National Insurance Company through the C. L. Frates agency.

Satisfaction with this program has not been achieved from a benefits standpoint, and there have been claims handling problems (largely resolved by utilizing the Frates agency as the processing office). It is difficult to develop an improved benefit package at this time, but our agent is continuing to explore the acquisition of another carrier which will offer the benefits desired at a competitive price.

In 1975, $22,463.31 was paid in claims against a premium income of $33,489 (loss ratio of 67%). The program has not sold well, principally because of the benefit package problems and claims problems mentioned above, and presently there are only 109 individuals and 14 groups (123 persons total) participating in the program. This small enrollment not only invites loss ratio problems but is an indicator that the plan needs to be redesigned, abandoned or moved to another carrier.

Action will be taken on this program during the next year.

Report of the FINANCIAL AID TO EDUCATION COMMITTEE and OKLAHOMA FOUNDATION FOR COMMUNITY MEDICAL CARE *(APPROVED)*

Committee Members

Lucien M. Pascucci, MD, Chairman, Tulsa
Stanley R. McCampbell, MD, OKC
Jack L. Richardson, MD, Tulsa
Arnold G. Nelson, MD, Midwest City
Orange M. Welborn, MD, Ada

SECTION I
FINANCIAL AID TO EDUCATION COMMITTEE

For the last seven or eight years the OSMA's Financial Aid to Education Committee has transferred its funds to the Oklahoma Foundation for Community Medical Care. The monies have been used for scholarships for medical students who agree to practice in a needy area of the State as determined by the Board of Directors of the Foundation. The funds for 1975-76 were transferred as usual; The sum of $10.00 per dues paying member or approximately $21,000.

SECTION II
OKLAHOMA FOUNDATION FOR COMMUNITY MEDICAL CARE

Members

Lucien M. Pascucci, MD, Chairman, Tulsa
Stanley R. McCampbell, MD, OKC
Jack Richardson, MD, Tulsa
Arnold G. Nelson, MD, Midwest City
Orange M. Welborn, MD, Ada
Mr. William Wise (Editor), Idabel
Mr. Guy Swadley, Jr., Eufaula
Mr. Lloyd R. Barby, Beaver
Mr. Archibald C. Edwards, OKC
Mr. J. M. Rector, III, El Reno

The Oklahoma Foundation for Community Medical Care was organized for the purpose of aiding in the replacement of the diminishing numbers of physicians in our rural and needy areas. The Foundation grants scholarships up to $5,000 per year to students who enter into a contract agreeing to practice in an area approved by the Board, one year for each year they receive assistance. Since the beginning of the program, eight (8) students have entered into contracts with the Foundation. Two of these have graduated and are currently practicing in various parts of the State, all rural. Below is a list of the students, their practice location or the status of their training.

James S. Gerber, MS III
John Ferguson, MS IV
James K. Robberson, MS III
John Sayre, MS IV
John Goff, Practicing, Miami, Oklahoma
Max Brazil, Residency
Randall Rauh, Practicing, Okmulgee, Oklahoma
Terry Wagoner, MS II

As you can see, most are still in some form of training program.

The Foundation also acts as the coordinator with communities who wish to enter into similar contracts with students. In some cases the student's financial aid is co-sponsored by the community and the Foundation. Such arrangements have been entered into with the communities of Perry, Sayre and Frederick.

Because of a shortage of funds and other programs that have been instituted within the past year, the Foundation did not make any commitment of its funds in 1975. However, there will be funds available for another scholarship in 1976.

The last session of the Oklahoma Legislature passed a Physician Manpower Training Act which created a Physician Manpower Commission and appropriated a substantial sum of money to finance students in medical school. The State operated program is modeled after the Foundation program. Its funds are used for both MD and DO students and 37 scholarships were granted in 1975.

In addition to the scholarship funds the Commission also has available monies for the purpose of helping finance internship and residency programs in hospitals throughout the State, but specifies that a certain portion of the money must be spent in rural areas. The total funds sought by the Commission for 1976 total $705,000.

In addition to the State program, students also have available the National Health Service Corp. which operates on about the same basis, and the National Congress has under consideration a Health Manpower Act which would require service in needy areas if financial assistance was accepted.

As the House can see there are a number of programs that students have available for them with financial resources that far exceed those of the Association. Delegates can take pride in the fact that the program started by OSMA was emulated by the State.

The Delegates should not consider this report as an implication that we should not continue the Foundation activities. However, in view of the new programs developed as reported above, a continuing assessment should be made of the Foundation programs.

RECOMMENDATIONS:

This is an information report to the House of Delegates.

Report of the PHYSICIANS COMMITTEE April 10, 1976 *(APPROVED)*

Physicians Committee Members

Ed Calhoon, MD, Chairman, Beaver
M. Joe Crosthwait, MD, Midwest City
Martin H. Andrews, MD, Oklahoma City
Arthur F. Elliott, MD, Oklahoma City
James B. Eskridge, III, MD, Oklahoma City
Robert A. McLaughlin, MD, Oklahoma City

The Physicians Committee of the Oklahoma State Medical Association is responsible for counseling or offering assistance to physician-members who are experiencing personal, professional, mental, or physical problems. According to the OSMA Bylaws, the Committee may offer such counseling and/or assistance if a physician-member of the Association requests it. The Committee may also offer its assistance at the recommendation of another association, committee, council, physician-member, or component society. According to the Bylaws, counseling sessions are to be considered privileged and no written record or minutes are to be recorded. Counseling is unofficial and non-disciplinary.

Since its inception the major obstacle faced by the Physicians (Care) Committee is a lack of understanding and/or visibility with the members of the Association. In many instances, the Committee is not able to be as effective or as useful as it would like due to a lack of referrals. During the past year the Committee has discussed various ways to gain this understanding and visibility and to make its purpose more widely known. This appears to be a primary need at this point and an internal project will be undertaken soon to accomplish this purpose.

All members of the Association need to fully understand that the Physicians Committee's *only* purpose is to provide help when it is needed. To accomplish this, a low-key publicity program will soon be undertaken with cooperation from the OSMA staff. News articles designed to explain the Committee's purpose and to give the Committee much needed visibility will be placed in the *"OSMA JOURNAL"* and in "OSMA NEWS." A separate brochure which would fully and completely explain the purpose of the Physicians Committee is now being considered. It is the Committee's hope that these two projects will accomplish their expressed

purposes and will aid the Committee in fulfilling its goal.

RECOMMENDATIONS:

1. That the Committee continue providing counseling and assistance to physician-members as it is requested and/or needed;

2. That the OSMA membership be informed as to the Committee's purposes and objectives and that the membership be urged to cooperate in finding and assisting in member-cases; and

3. That the Committee be authorized to develop appropriate materials for distribution which will aid in this project.

Report of the COUNCIL ON CONTINUING MEDICAL EDUCATION April 10, 1976 *(APPROVED)*

Kenneth W. Whittington, MD, Chairman, Bethany
Royce B. Means, MD, Lawton
Ralph L. Buller, MD, Hydro
Clarence P. Taylor, MD, Ada
John W. Drake, MD, Oklahoma City
Jack W. Parrish, MD, Seminole
W. Ed Dalton, MD, Oklahoma City
John R. Adair, MD, Ardmore
Irwin H. Brown, MD, Oklahoma City
David E. Browning, Jr., MD, Tulsa
James F. Tagge, MD, Enid
James D. Loudon, MD, Shawnee
James C. Smith, MD, Tulsa
John A. Blaschke, MD, Oklahoma City
Wendell L. Smith, MD, Tulsa
Hal B. Vorse, MD, Oklahoma City

SECTION I Introduction

Assuring continuing professional competence is a matter of concern for every professional group. Public accountability is demanded by units of government and consumer organizations. Accepted ability by virtue of licensure is no longer sufficient. Many professional groups fearing further outside encroachments into their professional lives have initiated a variety of programs to answer the competency question. This council is responsible to the membership for the continuing medical education of physicians and for recommending to the House of Delegates the adoption or rejection of programs that are designed to assure the continued high standards of medical excellence required for membership in the association. We also have the responsibility of reviewing course material offered to non-physician members of the health team. They, like our colleagues have a responsibility to continue their education to maintain the proficiency necessary for rendering appropriate care in an increasingly complex and technical health care arena.

In previous annual sessions, OSMA delegates have expressed the importance of physicians' continuing their education — "medical education is a continuum beginning upon entry into medical school and ceasing at death or retirement." While the importance of continued training is easily endorsed, the methodology of accountability is much more difficult. The House has acknowledged that attendance at medical courses does not necessarily result in changed practice habits but it has encouraged all physician members of the association to meet the educational requirements of the Physicians Recognition Award and Specialty Society membership. Thus, the Delegates have already adopted a policy that;

(a) continuing medical education is essential to good medical practice; and

(b) reporting attendance at educational courses for the purpose of meeting minimum requirements for continuing education recognition is reasonable.

In fact, the House adopted a Council report in 1973 urging members to voluntarily keep records of their participation in medical education courses.

A portion of this report will review in more detail the subject of requiring continuing medical education for physicians.

SECTION II OSMA—OUHSC Liaison

The Council and the Department of Postgraduate Medical Education for Physicians — OUHSC, continue to work together in sponsoring courses for physicians. The Department is accredited by AMA, thus OUHSC courses are approved for credits by various organizations that issue or require continuing education. AMA continues to encourage medical associations and their components to become official AMA accreditation agents. Heretofore this

Council has rejected the AMA plan on the basis that through co-sponsorship with OUHSC we had no need in becoming an accrediting body. However, the plethora of courses being offered indicates that we need to re-appraise our position. Oklahoma medical and health related organizations offer substantially more courses now than were offered a few years ago. Since OUHSC is the only AMA accrediting agency in the state it is unknown how many offerings there actually are, but if we compare to the national trend the number of courses to be offered in 1976, there will be nearly twice what was offered in 1974. In addition, the number of sponsors continues to increase:

Reported AMA Accredited Courses

Year	Courses Reported	Sponsors	Medical Schools	Hospitals	Other
1972-1973	2,082	253	957—46%	343—16%	782—38%
1973-1974	2,441	287	1,061—43%	426—18%	954—39%
1974-1975	3,677	393	1,516—41%	652—18%	1509—41%
1975-1976	4,862	554	1,920—40%	919—19%	1923—41%

As one can see, the traditional role of medical schools as the "mother house" for medical education is gradually eroding as more courses are offered and as the trend in hospital education increases.

If continuing education is to become a requirement of any sort there will need to be a quality review of course offerings. It is obvious that Irwin Brown, MD, Director of the OUHSC Department of Continuing Education will not be able to review and approve all courses. The Council feels there is a role for the association in the accreditation process as the recommendations of the report will show.

In addition to its other activities with OUHSC, the council cooperated with the Department of Human Resources to survey physicians on their interest in utilizing the services of the Televised Instruction System. While the survey indicates a positive response, the mechanical, technical and legal problems associated with using the system eliminates it (at least at the present time) as a teaching tool for physician education. In a meeting with Provost William Thurman, MD, Council representatives requested that practicing physicians be advised of the many educational opportunities available through the OUHSC Medical School Library. In early Spring, physicians began receiving "UPDATE," an OUHSC publication covering medical education opportunities offered by the Center. The newsletter is published about every six weeks. A Sample copy is in the packet.

Summit is the most significant medical education endeavor produced for Oklahoma doctors. Your Council Chairman has served as Scientific Program Chairman of Summit this year. With the cooperation of several of the Department heads at the Medical School, Summit has organized two special seminars on OB-GYN/Surgery and Pediatrics/Internal Medicine, which we hope will receive favorable response from the membership.

As evidenced by this section of the report, the Council has received excellent cooperation from OUHSC officials and professors.

SECTION III
Liaison With the American Medical Association

In 1971, the Council published, with the help of the OSMA Journal's editorial board and staff, a special issue devoted almost entirely to continuing medical education and promotion of the AMA Physicians' Recognition Award. The issue received considerable attention especially at AMA and since that time, we have sustained a close relationship with the departments of AMA that work in Physician Education Programs. In January of this year, the AMA, OSMA and Tulsa County Medical Society co-sponsored a two-day Regional Medical Education Program in Tulsa. Physicians in a three state area were invited and the session was well attended. Courses included Child Care in the Emergency Room; Financial Management Colloquium; Basic Life Support-Cardiopulmonary Resuscitation; Recent Advances in Cardiac Management; Dermatology for Non-Dermatologists; and Management of the Critically Injured Patient. Both local and national speakers participated in the Scientific presentations. The AMA now plans to conduct some sub-regional short courses (3 to 4 hours) in cities of 30,000-40,000, and has solicited our cooperation. AMA handles all the mechanics of the regional and sub-regional programs including printing programs, faculty, etc. However, they do depend heavily upon local physician talent for the selection of sites, dates and course content. They also ask that state and county societies promote the sessions in their official publications.

As mentioned earlier we have endorsed the AMA Physicians' Recognition Award; in the three year period 1972-1974, 237 Oklahoma physicians enrolled in the program. Nation-

ally, AMA issued 16,768 awards in 1974.

For the last several years, AMA has encouraged state societies to become approved by the Council on Medical Education for accrediting CME programs and courses. As of now, 48 state and territorial societies have been so approved. The reasons for not seeking accreditation privileges have been alluded to earlier in the report; and as mentioned it is the council's opinion that we should seek approval.

SECTION IV

Liaison with Oklahoma City Clinical Society, the Oklahoma Academy of Family Physicians, and the Oklahoma Board of Medical Examiners.

The creation of Summit a few years ago established a relationship between the Council, OAFP and OCCS that has improved medical education opportunities for physicians. The three participating organizations for three years have organized one of the most successful state medical meetings in the country. A recent survey conducted by the Texas Medical Association found that the most successful state meetings are those that have outstanding scientific sessions. Summit with 20 hours of Category I Credit and scientific sessions for almost every specialty of medicine must be considered an educational success. The increasing attendance and continued support by drug manufacturers supports the joint concept started four years ago by the academy and the clinical society. As the number of medical meetings continues to rise, it will be more and more difficult to sustain quality meetings of the magnitude of Summit. The excellence of the meeting is further attested when one realizes that in addition to the outstanding scientific sessions, there are socioeconomic programs with national speakers, social and sports events, all without a registration fee. In fact, in prior years, Summit returned a small profit to its founders. The council would like to congratulate the officers, leaders and staff of Summit and encourage all Oklahoma physicians and their wives to participate in its program next month — May 7-9.

The Council also maintains a close relationship with the State Board of Medical Examiners, who have the licensing authority over physicians. The Board has under consideration the proposition of requiring minimum continuing medical education for re-licensure of physicians. Seven states have imposed such requirements and it was anticipated that the legislature might consider such a statute while debating the passage of SB 622 — the medical malpractice bill. The Board prefers that no such act be passed, but recognizes the potential for such action based upon precedents set in other states.

SECTION V

Summary and Recommendations

The Council is of the opinion that the matter of accreditation and required continuing medical education cannot be ignored. Whether "report cards" assure the continuing competence of physicians or not is assuredly a valid question. However, the concept of classroom attendance, testing and credentialing have long been established in our society. Public accountability by professional societies for the conduct of its members is likewise expected. Not many years hence, physicians would not be accepted for hospital staff privileges unless they were members in good standing of their county and state medical societies. Though not madatory for practice privileges, membership in one's professional association has always been regarded by the public as an indication of a physician's professional competence.

The public expects the medical association to "police its own" and assure that the practitioners of this state are competent to practice their field of endeavor, and factual proof of that is increasingly required.

The House of Delegates could take the position that assurance of competency is a matter for the state and thereby encourage the State Licensing Board to develop its own program of credentialing. But, by so doing, you would necessarily require the state to develop an accreditation process for all medical education courses. It appears to the council that the entire matter of accreditation and credentialing would best be handled by the medical association, its component societies and its professional society partners.

We are also of the opinion that 90% of the association membership is already meeting the credit hour requirements for many of the various recognition awards. The Council feels the advantages of required continuing medical education include: better physician services and better patient care; the potential for re-

ducing malpractice insurance rates; it is a good demonstration of medical leadership; it will enhance the public image of organized medicine; and it will increase the availability of medical programs. To the contrary, we see the disadvantages as being; the ill will that will be created with some association members; that we will be subjecting our members to a requirement that has not proven to improve patient care; and that minimum requirements become maximum achievements.

RECOMMENDATIONS:

1. The Council on Continuing Medical Education be instructed to develop the criteria and necessary accompanying accreditation procedures for required continuing medical education for Association Members;

2. That the amount of required continuing medical education be evaluated in a three-year period.

3. That an official accrediting body be created by OSMA in consultation with OUHSC, the Board of Medical Examiners, the Foundation for Peer Review, Oklahoma Academy of Family Physicians and various specialty and medical organizations for the purpose of accrediting continuing medical education courses not otherwise accredited by recognized accrediting agencies;

4. That the completed plan and implementation procedures be submitted to the House of Delegates at its meeting in 1977 with the first enrollment period to commence in January 1978 and the first three-year period to conclude in December 1980;

5. That the participating organizations in Summit be commended for their fine programs and encouraged by the House to continue their cooperative arrangement.

Report of the MEDICAL CENTER LIAISON COMMITTEE

(APPROVED)

April 10, 1976

C. S. Lewis, Jr., MD, Chairman, Tulsa
Robert Ellis, MD, Oklahoma City
Jack Parrish, MD, Seminole
Thomas N. Lynn, MD, Oklahoma City
Orange M. Welborn, MD, Ada
Earl M. Bricker, MD, Oklahoma City
David Mock, MD, Oklahoma City
Wendell L. Smith, MD, Tulsa
Robert J. Rutledge, MD, Oklahoma City
Kenneth Whittington, MD, Oklahoma City
Howard P. Mauldin, MD, Oklahoma City
Billy Dale Dotter, MD, Okeene
James W. Murphree, MD, Ponca City
G. Rainey Williams, MD, Oklahoma City
M. Boyd Shook, MD, Oklahoma City
C. B. Cunningham, MD, Clinton
William Thurman, MD, Oklahoma City
Malcolm E. Phelps, MD, El Reno

At the writing of this report, last year the State Legislature had under consideration SJR 22 which would have legislated the composition of the College of Medicine's Admissions Board. In an effort to forestall the legislated board, this committee proposed to the House of Delegates that a study be conducted by a committee of the association consisting of two representatives from each of Oklahoma's six congressional districts, plus five medical center representatives. The OSMA resolution was successful in that the SJR 22 was not passed. However, before the study could commence the O.U. Regents voted to enlarge the Board to 54 members with 24 members coming equally from Oklahoma's six congressional districts. Ten members are practicing physicians who hold clinical faculty appointments and ten members are medical students. The Regents further requested that the Oklahoma State Medical Association be asked to aid in the selection of the 24 members who represent the six congressional districts. Arnold G. Nelson, MD, President of the Association contacted members of the Medical Center Liaison Committee, County Society Presidents, members of the Board of Trustees and other physicians across the state, requesting nominees for the 24 positions. After an orientation process in late August, the final recommendations were submitted to Dean Lynn.

The new Admissions Board is functioning well. There are a few problems that as one might expect with any new group; but for the most part, we are advised by Health Sciences Center Officials that the Board is serving well. Serving on the Admissions Board requires substantial sacrifice since there are such a large number of applicants interviewed. Members of the board meet weekly to interview the applicants and the entire board meets once a month to review the interviews. The process is long and arduous and the final class is not selected until summer, before the fall class begins.

The committee assisted the Tulsa Chamber of Commerce and the new branch of the School of Medicine at Tulsa in conducting the "Oklahoma—Meet your Future Physician—Meet the Tulsa Branch" Program in late September. Other sponsors included the Tulsa County Medical Society and the Oklahoma Council for Health Careers. Students and Residents of the new College of Medicine were invited to participate and 50-75 communities were asked to send community leaders to the affair. Governor David Boren and Chancellor E. T. Dunlap were principal speakers at the event. The objective of the program was to match up medical communities with prospective doctors.

Again this year, the Medical Center Liaison Committee acting for OSMA, co-sponsored a legislative reception at the Faculty House for the members of the Oklahoma Legislature. OSMA Officers and committee members were invited, along with faculty representatives. During the cocktail reception, about half of the members of the Oklahoma Legislature attended.

Doctor William Thurman attended the last meeting of the Medical Center Liaison Committee and a number of suggestions were discussed with the new Provost. Some of these the committee is pursuing or has recommended that other appropriate Councils or Committees of the Association investigate.

The recommendations include:

Proposition: Participation of the OU Health Sciences Center Faculty in planning and conducting Summit '76.

Result: Nine Departments of the OU Medical School are participating in the Scientific Program of Summit '76.

Proposition: Joint accreditation of medical programs by OSMA and OUHSC's Department of Continuing Medical Education.

Result: OSMA's Council on Continuing Medical Education recommended that such an arrangement be formalized and a full report given in the House of Delegates 1977 meeting.

Proposition: Utilization of Televised Instruction System for medical education.

Result: Investigated and found to be impractical.

Proposition: Increased publicity among physicians about the educational opportunities via the OU Medical School Library.

Result: UPDATE on Continuing Medical Education is a new publication of the OUHSC giving information about continuing medical education programs at the school.

Proposition: Greater utilization of OSMA *Journal* to announce continuing medical education opportunities.

Result: Formal liaison on the announcement of courses between the Office of Information, OUHSC and OSMA Director of Communications.

Proposition: Increased publicity about the success of the Family Practice Program and the new satellite programs to be started.

Result: No formal action taken on this proposal.

In an effort to increase the committee's input for medical students and with the approval of President Nelson, a medical student has been appointed to our committee.

At the writing of this report last year, the committee was involved in efforts to secure passage of legislation creating the Physician Manpower Training Commission. HB 1552 (as reported in the State Legislative Committee's Report) was passed and a total of $264,000 was appropriated for the purpose of increasing the number of Internship and Residency Programs and to help assist students through school who are willing to practice medicine in a needy area of the state. The Chairman of the Committee is also a member of the Physician Manpower Commission as is Jack Parrish, MD, Seminole and Billy Dale Dotter, MD, Okeene. There are two Osteopaths on the Commission and two laymen. As mentioned in earlier reports, this may be one of the most significant pieces of legislation ever sponsored by the State Medical Association. In the next five years, it is anticipated that an additional 7-8 million dollars will be spent in internship and residency programs and one million dollars in assisting students who will practice in needy areas of the state.

RECOMMENDATION:

That the activities of the Committee be approved and continued.

July 10, 1975

Arnold G. Nelson, MD
President
Oklahoma State Medical Association
601 NW Expressway
Oklahoma City, Oklahoma 73118

Dear Doctor Nelson:

Please convey to the Board of Directors and membership of the Oklahoma State Medical Association my most grateful thanks for their efforts in connection with our Health Professions Student Loans. The check just received in the amount of $2,735 brings the total OSMA contributions to $11,000. On a one-ninth matching basis these contributions have enabled the College of Medicine to secure $99,000 in federal loan funds over the past three years. The following points are important and you may wish to convey them to your members:

1. All of the funds are *loaned* to medical students with the eventual repayment of those funds being reloaned on a revolving basis to other students. In effect, then, the real worth of the contributions can be measured in terms of the number of loans made from a perpetual revolving account over an indefinite period.

2. Added to the $11,000 contributed by the OSMA, the total amount made available was $110,000.00

3. Our Regional Office informs us that any new legislation will *not* contain appropriations for Health Professions Scholarships, which means that unless a student wishes to negotiate a return service contract, he must borrow the full amount of his need each year.

You can see how tremendously important this program is to the students in the College of Medicine and why we are so appreciative of your efforts.

Sincerely,
Thomas N. Lynn, MD
Acting Dean

amc:sf
cc: David Mock, MD
Mr. Dave Barrett

Special Report of the COUNCIL ON CONTINUING MEDICAL EDUCATION *(APPROVED AS AMENDED)*

At a Board of Trustees meeting in 1975, Tom Lynn, MD, then Acting Dean, OU College of Medicine requested that the Board of Trustees consider an OSMA-sponsored program for the purpose of endowing a Professional Chair at the OU College of Medicine. After discussion, the Board referred the matter to this Council for study and recommendation.

Following is the Council report:

Medical schools are financed with monies from four sources — state funds, federal funds, endowments and self-generated income through practice plans. The percentage of each varies from school to school but generally speaking, for state supported schools about one-third comes from state assistance, one-third from federal grants and aid and one-third from practice plans and endowments. The OU College of Medicine falls within this pattern except that state assistance waxes and wanes with each new political administration and there are no substantial endowments. The school has relied heavily on its own ability to generate income and support from Federal Funds. The future of federal funding is unpredictable, at best and perhaps will be phased down or out in the forseeable future. Thus, the School is in a real dilemma. The legislature has mandated an expansion program of substantial magnitude — in 1970 there were 95 Medical School graduates; in 1980 there will be 176; in addition there is currently a major expansion of residency programs, from 137 in 1975 to 276 by 1980.

While the state legislature has shown more concern over the schools budget in the last two years, it is doubtful that they are willing, or able, to compensate for a withdrawal of federal funds.

It is not unusual for medical schools to be heavily endowed with private funds; unfortunately, our school is not. Several unique characteristics of the OU College of Medicine may account for the lack of substantial bequests to the school.

The founding of the Oklahoma Medical Research Foundation was for the purpose of providing research support to the medical school but because of encumbrances placed on a major contribution to the foundation it does not directly support the activities of the college of medicine. A few professors who hold joint appointments at the school and the foundation receive minor stipends from the foundation, but the contribution is not significant to the education program. The Foundation has a fine statewide reputation and because of its origi-

nal purpose and because of its location in the OUHSC complex it is felt that many contributions are mistakenly made to the foundation with the thought they are to accrue to the support of the College of Medicine.

The physical separation of the OUHSC campus from the University of Oklahoma may contribute to the lack of endowments. The Oklahoma University Development Foundation, which is Norman based, naturally would have an advantage in the solicitation of funds since they represent the entire University community and all its various colleges. Visitors to the Norman campus would include all alumni whereas visitors to the Oklahoma City Campus are more likely to be its physician graduates.

A third reason the school may not be well endowed is the fact that by most standards, it is relatively young and simply has not had time to gather the alumni nucleus necessary to bring the school large sums of money.

The Oklahoma University Development Foundation — Health Sciences Center branch was created in 1968 for the purpose of endowing the health sciences and it has been moderately successful. However, most of the money attracted has been for "bricks and mortar" rather than educational programs.

Based upon the above, it can be concluded that to continue a viable medical education program in Oklahoma, alternative sources of funding seem appropriate and necessary. Traditionally, alumni associations act as the catalyst for endowment funding and certainly they should be included, however it is not without precedent for state medical associations to initate programs to support medical schools. Oregon has recently funded a professor position at its state school. In 1968 OSMA solicited its entire membership to support the "Nero" bond issue, that resulted in major capital improvement projects at OUHSC; and since 1972 association members have contributed to a special students assistance fund to aid OU Medical School students. Furthermore, since the medical school benefits all state physicians both directly and indirectly, regardless of their school of graduation, it appears proper to design the support group to include as many physicians as possible.

In summary, the Council finds:

1. The School needs the financial stability that accompanies endowment monies;

2. There appears to be no reason why the association should not be the founders of an endowment fund for the school; and

3. While there are Foundations organized to benefit the school, they do not have sufficient identity to attract membership support or they do not contribute substantially to medical school programs.

RECOMMENDATION:

1. The Oklahoma State Medical Association should devise a mechanism to attract contributions for an endowment to support medical education and that a complete proposal, with adequate safeguards be developed for presentation to the Board of Trustees for approval and implementation that include assurances that the funds will be equitably distributed throughout OUHSC's Medical College and Branches and that appropriate acknowledgements to OSMA be guaranteed.

Report of the
COUNCIL ON PUBLIC POLICY
April 10, 1976
(REFERRED TO THE BOARD OF TRUSTEES)

Council Members

M. Joe Crosthwait, MD, Chairman, Midwest City
R. Barton Carl, MD, Oklahoma City
Charles N. Atkins, MD, Oklahoma City
Gerald L. Beasley, Jr., MD, Duncan
Kent Braden, MD, Oklahoma City
Eugene S. Bell, MD, Tishomingo
James B. Eskridge, III, MD, Oklahoma City
Jack Fetzer, MD, Woodward
James Funnell, MD, Oklahoma City
Tom S. Gafford, MD, Muskogee
Edward D. Greenberger, MD, McAlester
Homer D. Hardy, MD, Tulsa
Floyd F. Miller, MD, Tulsa
Jake Jones, MD, Shawnee
Rex Kenyon, MD, Oklahoma City
Jerold D. Kethley, MD, Shawnee
William M. Leebron, MD, Elk City
Jack L. Richardson, MD, Tulsa
Casey Truett, MD, Norman
Marion C. Wagnon, MD, Del City
Orange Welborn, MD, Ada
Kenneth Whittington, MD, Bethany
George Randels, MD, Midwest City
Harlan Thomas, MD, Tulsa

State Legislative Committee

R. Barton Carl, MD, Chairman, Oklahoma City
S. N. Stone, MD, Oklahoma City
Royce C. McDougal, MD, Holdenville
Joseph W. Stafford, MD, Enid
James B. Lockhart, MD, Tulsa
William G. Bernhardt, MD, Midwest City
Edgar W. Young, Jr., MD, El Reno
George H. Kamp, MD, Tulsa
Lanny F. Trotter, MD, Stillwater
Raymond L. Cornelison, MD, Midwest City
Francis Oakes, MD, Oklahoma City
C. Alton Brown, MD, Oklahoma City
Karl K. Boatman, MD, Oklahoma City
Robert S. Ellis, MD, Oklahoma City
John R. Smith, MD, Oklahoma City
Marion C. Wagnon, MD, Del City
Perry Lambird, MD, Oklahoma City
M. K. Braly, MD, Woodward
William L. Hughes, MD, Oklahoma City
Worth M. Gross, MD, Tulsa
Wilbur C. Lewis, MD, Midwest City

Medical Heritage Committee

R. Palmer Howard, MD, Chairman, Oklahoma City
Clinton Gallaher, MD, Shawnee
B. E. Blevins, MD, Midwest City
Vance Bradford, MD, Oklahoma City
Neil B. Kimerer, MD, Oklahoma City
E. C. Mohler, MD, Ponca City
Harold J. Black, MD, Tulsa
George H. Garrison, MD, Oklahoma City

SECTION I
COUNCIL ACTIVITIES

The Council on Public Policy is responsible for several of the Association's more critical activities. It is not only responsible for developing and improving the profession's public image, but it is also responsible for internal communications and for reviewing both state and federal legislation. Even more important than the constant review which the Council is involved in is the positive steps it must take to develop new programs and to counteract third party interference. The past year proved to be one of the most active in the Association's history, and the Council on Public Policy was called upon to do more than perhaps ever before.

At last year's annual meeting the House of Delegates approved a resolution directing the Association to assume a stance of "non-participation" with regard to the November 29th, 1974, utilization review regulations issued by the Department of Health, Education and Welfare. That resolution stated, "that the physicians of the State of Oklahoma will continue utilization review and peer review on an individual basis, and will not participate in utilization review as outlined in the above cited regulations . . ." The resolution further instructed the Association to organize a public information campaign and authorized the Board of Trustees to establish an adequate budget to carry out the campaign through a voluntary $100 membership assessment.

Immediately after the annual meeting, a Tulsa-based public relations/advertising firm was retained to prepare a public relations schedule and necessary campaign materials to be used in a public information campaign designed to educate the public, particularly Medicare and Medicaid patients, about the deleterious effect the original utilization review regulations would have.

The expressed purpose of the campaign was to generate at least 100,000 letters to President Ford urging him to have HEW Secretary Caspar Weinberger withdraw the regulations. The campaign was to officially begin on June 13th with press conferences in Tulsa and Oklahoma City and was to center around a series of newspaper ads to appear in every state daily newspaper.

At the same time a special Executive Committee of the Council was asked to develop an alternate utilization review plan which would better meet the capabilities of Oklahoma's smaller hospitals. This committee consisted of the following persons: M. Joe Crosthwait, MD, Chairman; Arnold G. Nelson, MD, Kent Braden, MD; James B. Eskridge, III, MD; and Kenneth W. Whittington, MD.

This committee met with the Oklahoma Congressional Delegation in Washington, DC, in May, 1975, and discussed the development of an alternate plan with the delegation and with top level federal officials. As a result of this meeting, Theodore Cooper, MD, HEW assistant secretary for health, invited the OSMA to develop an alternate plan for his consideration. (Complete details are available in the Report of the Board of Trustees.)

Although the public information/advertising campaign authorized by the House of Delegates was completely developed, it was decided

not to implement the plan until a court decision on a lawsuit filed by the American Medical Association against the HEW regulations was rendered. AMA officials were confident their lawsuit would be successful and they expressed concern that a public campaign stressing non-participation would jeopardize the lawsuit and work against the prosecution. The AMA asked that the OSMA delay its campaign for at least 60 days to see if a favorable judgment would be rendered. As a result of the AMA lawsuit and a tentative approval of an alternate utilization review concept submitted to Doctor Cooper, the OSMA decided to keep its public information campaign in readiness, but to delay its implementation until decisions on the lawsuit and the OSMA concept were made.

During the period the OSMA agreed to delay its campaign, the new Secretary of HEW David Matthews withdrew the November 29th regulations in the process of settling the AMA lawsuit out-of-court. During the same time, the OSMA pushed ahead with its proposed alternative to the federal utilization review guidelines, and as a result of these two occurrences, it was not necessary to implement the campaign. The general guidelines of the campaign and the ads and other materials developed before the original regulations were withdrawn, however, are still available to the Association and can be used if future developments in Washington require it.

New utilization review regulations have only recently been released by HEW, but authoritative sources have indicated the new regulations will not be operable for at least nine months. In the meantime, the OSMA and the Oklahoma Foundation for Peer Review are continuing work on a one-year demonstration project as an alternative to the original and any future federal guidelines for utilization review. This plan, the Oklahoma Utilization Review System (OURS) has the approval of the OSMA Board of Trustees, the Oklahoma Osteopathic Association and the Oklahoma Hospital Association. It is currently in process as a federally-approvable and demonstration project under a special waiver application, although final federal approval has not yet been granted. (For additional information, see the Report of the Board of Trustees and Appendix B.)

As a result of the successful AMA court action against the November 29th, 1974, utilization review regulations and the OSMA's success in gaining at least tentative approval of a model concept for review, the advertising fund raised through the $100 voluntary membership assessment was not used to finance the planned advertising campaign and a balance of $55,936.68 remains earmarked to fight third party intervention into the practice of medicine. After the advertising campaign became unnecessary, the OSMA volunteered to return each contributor's contribution, but without exception, contributors decided to leave the fund intact on a contingency basis in order to forestall through public relations and/or advertising any future intervention.

UTILIZATION REVIEW FUND

Assessment Income	$49,085.00
Funds from 1965 Assessment	11,504.51
Total	$60,589.51
Expenses	4,652.83
Balance	$55,936.68*

*For a more detailed account see page 13 of the Report of the Board of Trustees.

Although in this particular instance successful court action made it unnecessary to implement a public information campaign against HEW's utilization review regulations, associated events proved to the Council that an on-going and well-designed public relations campaign is imperative.

This belief was reinforced by a management study performed by Don Taylor, executive vice president of the Iowa Medical Society. In his report, researched and written during the summer of 1975, Mr. Taylor complimented the OSMA staff, but pointed out that the OSMA was grossly understaffed in relation to the workload. Mr. Taylor further said there was a need for a full-time professional in public relations. As a result, the OSMA Executive Committee, with the concurrence of the Board of Trustees, hired Richard L. Hess as "Director of Communications." Mr. Hess is now responsible for internal and external communications. He is 27 years old, has a Masters Degree in journalism (public relations and communications research) from the University of Oklahoma. Before joining the OSMA staff, Mr. Hess had worked two years as Communications Director of the Interstate Oil Compact Commission.

Several changes to the OSMA's internal and external communication efforts have been put into effect during the past year. The OSMA *Journal,* one of the principal means of internal

communications, now features a monthly interview with leaders of medicine and government. The interview series is designed to give OSMA members timely information from top-level decision makers about issues which affect the medical profession.

Publication of the monthly OSMA COMMENT has been replaced by a new monthly newsletter, OSMA NEWS. With a growing need to communicate more fully with the membership, the Council felt it was imperative that our newsletter be expanded to meet increasing communication requirements. OSMA NEWS is a four-page typeset newsletter with color and half-tone capabilities. Approximately two-thirds of the cost of producing OSMA NEWS is defrayed by two full-page ads, making the cost to the Association approximately the same as the two-page, mimeographed newsletter it replaced.

During the past two and one-half months, the Association also sponsored a special newsletter, OSMA MALPRACTICE UPDATE, which was published to keep the membership informed about the malpractice insurance problem and about the OSMA-backed malpractice bill, Senate Bill 622. This newsletter was printed on four occasions to alert the members about the bill and to solicit their help in getting it through the Oklahoma Legislature. Included with the newsletter were inserts such as rosters of the House and Senate, a mock billing statement pointing out what Oklahoma doctors would pay for insurance if SB 622 failed, and other items designed to generate support for the bill. With one exception, the newsletter was mailed first class because of several time constraints. The total cost of producing and mailing the newsletter was $2,300.00. The bill passed the Senate 42-1, and it passed the House 88-3.

A reprint of one issue of OSMA MALPRACTICE UPDATE was provided to the Arkansas Medical Society at their request to demonstrate what doctors in Oklahoma were doing about the problem.

Still another project sponsored by the Council was a "statement stuffer" reading:

TO MY MEDICARE PATIENTS
YOUR MEDICARE BENEFITS ARE
BEING CUT.

This leaflet which was distributed by the OSMA to all of its members was designed to explain Public Law 92-603 and its effect on Medicare reimbursements. This law, passed in 1972 but not implemented until 1975, instructed the Secretary of HEW to roll back Medicare payments toward physician charges to the amounts physicians were charging in 1969 and 1970, plus a small yearly increase to be set by the secretary. At the same time physicians were receiving their leaflets, press releases were sent to every newspaper, radio, and television station in the state.

The leaflet was extremely successful and largely responsible for a lack of complaints from Medicare patients. Two printings of this leaflet were made due to a greater than expected demand.

A new project authorized by the Council is now in production. This project will be a new "Medical Update" series which will place an attractive and informative three-pocketed placard in every doctor's office in the state. This will be an on-going project with the three brochures treating the pressing issues in medicine.

The first three brochures will be entitled: "Malpractice Insurance — A Patient's Problem Also"; "National Health Insurance — Is It Worth the Costs?"; and "Medical Profession — Here to Serve you!" The placard itself is completed, as is the first brochure on malpractice insurance. Samples of this project are located at the registration desk and throughout the hotel.

In addition to the formal projects designed to educate the public and to prevent the necessity of fighting a "rear-guard" battle, the Council is engaged almost daily in public relations through direct contact with the media. The Council on Public Policy, its direct OSMA staff person, and other members of the OSMA staff serve as direct links between the press and the 2,600 doctors located throughout the state. In this capacity, the Council provides a service to the press by organizing press conferences, by setting up interviews with OSMA officials and with officials from other medical organizations and by offering comment on issues such as physician advertising, drug substitution, "Living Wills" the legal definition of death, and many others. In additon, the Council and the OSMA public relations director work closely with feature writers in providing ideas and details about changes or advancements in medicine. The Council is currently organizing a Physicians Resource List which should aid the OSMA public relations director in providing this valuable service on short notice. This list will be regionally organized and will offer a list of doctors from various regions of the state

who have volunteered to act as medical representatives to the press.

RECOMMENDATION:

This report has outlined many of the projects the Council has been involved in during the past year, and it has described some of the projects we know need to be developed. One thing is certain, our public relations efforts must be increased.

Many issues now face the medical profession which would have a profoundly deleterious effect on the practice of medicine in this country. National Health Insurance is an issue which has still not been resolved. Similarly, great strides have been made in this state to conteract the malpractice insurance crisis, but much more still must be done.

The public must be informed and educated about these issues and the medical profession must make its views clearly known. Similar efforts must be taken with our own members. To do this, both internal and external communications must be increased and made more efficient.

The Council on Public Policy recommends a $100 membership assessment to aid in this effort. This money should be earmarked for public relations, and should be used to produce special projects such as the office placard, the special legislative newsletter, documentary films, and for other projects which may become necessary. The Council hopes that through the establishment of such a fund and through ongoing and effective public relations, both the public and the profession can be protected from harmful third-party interference.

STATE LEGISLATIVE COMMITTEE

INTRODUCTION

For the past two years, this committee has been unable to provide Delegates of the Association a complete legislative report. Long legislative sessions are the rule rather than the exception. Even though 1976 is an election year, it is doubtful lawmakers will abandon the Capitol building far in advance of the constitutional limit of 90 legislative days which will occur on the 9th of June.

Several major issues will contribute to the lengthy session.

Each year the struggle between Common Education and Higher Education intensifies. Schoolteachers in all categories are underpaid when salaries are compared to the regional and national averages. On the other hand, Higher Education continues in financial hardship with underfunded programs and expansion pressures. The Higher Education appropriation is of special importance to physicians since the medical center's budget is included in the bill. Last year Governor Boren was successful in securing approval from the O.U. Regents of an agreement to fund the Medical School at the budget request. Normally, all institutions in the Higher Education system are cut back from budget request because there are never sufficient monies to fully fund the total Higher Education budget. The Higher Education Alumni Council feels the medical school received "special consideration" last year and has spoken against full funding for the medical school if other institutions don't receive like treatment. Whether or not the school will receive sufficient funding is a major concern. Recent reports project that medical student tuition will double, and it's possible that at least one school in the Health Sciences might be dropped.

Medical matters still continue to reap increasing legislative attention. The committee has reviewed closely and taken positions on more than forty proposed laws. A large number of these were introduced to deal with the malpractice situation. Some were good, some were bad, all were well intended. All things considered, the committee feels quite fortunate to have been successful in assisting in the passage of Senate Bill 622 — the association sponsored medical malpractice act. At the writing of this report, the bill is waiting Governor Boren's signature, having passed the House and Senate by substantial margins. Barring unforeseen events, it will probably be signed by the time this report is considered.

The passage of SB 622 indicates the political "clout" of Oklahoma doctors and the medical care industry. The profession responded with tremendous enthusiasm to the committee's repeated requests for assistance, legislators from over the state told of the many contacts they received from their physicians and hospitals. The bill's success is also a good commentary on the cooperation of OSMA's officers, councils and committees. From the date the Board of Trustees authorized the formation of the Professional Liability Commission, various members of the association (and others outside the profession) worked to develop a bill that would aid in solving the problem and at the same

time was legislatively viable. For almost two years, councils and committees studied the insurance, social, legal and legislative aspects of the malpractice problem. After the Professional Liability Commission made its recommendations to the legislative committee, bills were drafted and re-drafted. All the while, the Public Relations Committee worked to inform physicians of the impending battle. Officers of the Association met with Governor Boren to seek support, changes again were made to accommodate the Governor's suggestions. Bill authors were discussed, consulted, rejected and finally selected. Interim Legislative Committees met to discuss various proposals; members of your committee testified time after time about the importance of doing something *NOW* before the crisis comes. Finally, it all came together and all the work, the time lost, the anxiety, the frustrations, the arguments, the criticisms, the mistakes became worthwhile. It doesn't always work that way — in fact, most times it doesn't. The tragedy is that it could happen a lot more often if we, as an association, would do what we can — what we did with SB 622.

Another major contributor to the success of SB 622 — other than the exhortations, the arm twisting, the phone calling and letterwriting — was the political actions of Doctors in the last statewide elections. Doctors have friends in the state capitol now — both Democratic and Republican — some of those are there because of OMPAC and some because physicians and their wives worked and campaigned for Senators and Representatives they liked (or against those they didn't). That is political *action*. That is what makes the system work. Every physicians should be involved in state legislative races either by selecting and working for and supporting his own candidate or by supporting OMPAC, whose board has consistently exercised good and unbiased judgment in supporting good candidates — not just candidates favorable to OSMA — but good representatives of the people who vote a philosophy reflective of their legislative constituency and doctors.

LEGISLATIVE DOCTOR OF THE DAY

Our volunteer "Doctor of the Day" program has familiarized our members with the legislative process and has helped lawmakers to understand more about the practice of medicine. The personal relationships that have been fostered and improved by this program have most certainly enhanced our rapport at the capitol.

Each legislative day, a volunteer physician serves in the third floor capitol first aid station, and with a nurse, he renders care to legislators and capitol employees. The association has been the principal sponsor of the program for nearly 12 years. This year we have experienced some real difficulty in securing the necessary supplies to stock the facility. Normally, the drug manufacturers and suppliers furnish the required products from sample goods. Because of this problem, and since supervision of the facility requires considerable time, we are suggesting approval of a recommendation to permit the Oklahoma City Hospital Council to become a co-sponsor of the First Aid Station. They have tentatively agreed, if the House approves, to supervise and stock the station with the necessary supplies and equipment at no cost to the association.

COMMUNICATIONS

Two years ago, the House of Delegates authorized the leasing of an automatic typewriter to improve our letter writing technique. This machine has proven to be one of our most effective tools. We can write 50-100 personal letters in one day with relative ease. The personal letter is a great improvement over our previous mimeograph and xeroxing processes. In fact, because the committee feels so strongly about personal letters, on occasion this year, we have employed private firms who own similar equipment to assist us in mass mailings.

DOCTORS' WIVES DAY AT THE LEGISLATURE

With the help of the Auxiliary and the Public Relations Committee, we again conducted a one-half day session at the State Capitol. The entire program was devoted to medical malpractice; speakers covered the insurance, legal and legislative aspects of the malpractice problem. Approximately 100 women from around the state attended the meeting which concluded at the Faculty House with a lunch and presentation by William G. Thurman, MD, Provost, OUHSC.

MALPRACTICE UPDATE

In an effort to more effectively communicate with our membership about the malpractice legislation, the Association's Council on Public Policy and new Director of Communications began publishing a legislative newsletter "Malpractice Update". The publication kept members of the Association up to date on

exactly what was happening at the State Capitol at various stages during the legislative journey of SB 622. "Update" was mailed not only to physicians' offices, but at times to their home addresses with an encouragement that wives become involved in the influence and process. Based upon the votes taken on SB 622, it appears that the special newsletter was indeed effective and contributed significantly to the passage of the bill.

SUMMARY OF BILLS

Listed below is a brief summary of the most important legislation reviewed by the committee during the last session of the legislature, and some of the carry-over bills which had not been disposed of at the last House of Delegates meeting. A recent issue of the OSMA *Journal,* August, 1975, contained a comprehensive summary of the bills passed during the first session of the 35th Oklahoma Legislature and this report will not include those bills.

Since the Legislature has not adjourned, the final disposition of a number of these proposals is still unknown and there is still a substantial number of important bills pending at the state capitol.

SB 622 — as mentioned in various reports to the House of Delegates, SB 622 is the most important medical legislation supported by OSMA in recent years and consumed an incredible amount of the committee's time and the association's resources. The compromise measure was hammered out after months and months of negotiations.

While it does not include all of the reform originally proposed by the Professional Liability Committee, it should make a substantial impact upon the future availability and cost of malpractice insurance to the health care industry. The law is sufficiently broad to include physicians, hospitals and other health care providers and therefore should be beneficial to a great number of health workers.

The data gathering process provided for in Section 1 will provide us the necessary information to document the malpractice insurance situation in this state in future years.

Probably the major provision in the bill is Section 2 which limits the time for filing actions to two years from the date of discovery or a maximum of three years; except that after three years, recovery can be made for actual medical expenses incurred.

Section 3 is a two-pronged attack to secure medical information. One provision provides that a patient may have access to his medical records without commencing an action; and the other provides that a patient waives the privileged communication with his physician by commencing an action that places his physical or mental health in issue.

Section 4 provides that it is a misdemeanor to refuse to comply with Section 3.

Section 5 qualifies the Doctrine of Res Ipsa Loquitur in that there can be a presumption of negligence only if foundation facts (where knowledge more than that possessed by the average layman is needed) are established by expert testimony.

Section 6 authorizes the State Insurance Fund to enter into the malpractice insurance business if it is deemed in the public interest and after certain stringent requirements are met. A copy of the bill, with the appropriate amendments is included in your packet, also a roll call vote.

HB 1160 — a repeal of the anti-drug substitution laws. After considerable controversy, the committee was successful in having shelved (apparently) HB 1160 which would have repealed Oklahoma's anti-drug substitution laws. The position of opposition is in keeping with the instruction of the House of Delegates by virtue of passing a Pottowatomie County Medical Society resolution introduced in the closing session of the House of Delegates last year.

HB 1552 — creating the Oklahoma Physician Manpower Training Commission. This law would certainly have to be considered one of the more important medical bills passed in the last few years. It provides for a state subsidy of internship and residency programs; and in effect, sets as a policy of the state, the recognition that postdoctoral training is a rightful obligation of the state. The new commission has three OSMA recommended members, two osteopaths, and two lay members. More details about the Commission's activities are included in the report of the Medical School Liaison Committee.

HB 1900 — Workmen's Compensation Act of 1976. Statewide publicity of this particular issue makes it hardly necessary to provide a detailed report; where after months of study, the Governor's Committee recommended passage of an omnibus workmen's compensation bill. It was a massive overhaul of the existing

statutes and would have been a major step in correcting an absolutely deplorable workmen's compensation system. Unfortunately, the bill did not receive favorable consideration and by legislative maneuvering has been killed for this year.

SB 236 — Permitting civil action against a physician who has committed negligence on an injured worker covered by workmen's compensation insurance. This legislation is perennial and apparently the committee has been successful in defeating it once again. Under existing case law, a physician has as an agent of the employer, an immunity from civil liability when caring for persons covered under workmen's compensation insurance. The Trial Lawyers have supported efforts to remove the halo for the past five or six years. It would have a devastative effect on malpractice insurance premiums.

SB's 591 and 595 — Both of these bills were introduced to either amend or repeal the law that permits a health care provider to render service to a minor without parental consent. The new law passed in the last session of the Legislature has not resulted in any gross abuses reported to the association.

A final report of the legislative action on medical bills will be published in an upcoming issue of the *Journal*.

Meanwhile, any information about any legislative matter of interest to the members of the House of Delegates or any OSMA member, can be secured from the OSMA headquarters.

RECOMMENDATIONS:

1. That OSMA continue an aggressive state legislative program and urge every Doctor and his wife to become actively involved in state politics, either by becoming active supporters of chosen candidates or by supporting OMPAC or both;

2. That OSMA continue the Doctor of the Day Program and authorize the Executive Committee to arrange co-sponsorship of the facility with the Oklahoma City Hospital Council, if acceptable arrangements can be made;

3. That the President of the Association and the Legislative Committee Chairman are authorized to send appropriate letters of appreciation to members of the Legislature and that all members are urged to contact their state Senator and Representative to express appreciation for passage of SB 622; and

4. That the House instruct the Council on Public Policy to inform all OSMA members of the passage of SB 622 and that a special *thanks* be expressed for the help given by OSMA members in successfully passing the bill.

HOUSE ROLL CALL ON SB 622

AYE

Abbott, Lonnie, Ada
Anderson, Robert, Enid
Bamberger, Thomas, Oklahoma City
Bengtson, L. H., Jr., Oklahoma City
Bennett, J. B., Okmulgee
Bernard, Spencer T., Rush Springs
Beznoska, Gordon, Geronimo
Bradley, W. D., Waurika
Bradshaw, Mark, Arnett
Brunton, Paul D., Tulsa
Caldwell, E. A. Red, Wilburton
Camp, George, Oklahoma City
Campbell, Terry L., Bethany
Cleveland, Charles, Tulsa
Congahan, Dorothy, Tonkawa
Converse, Kenneth, Tishomingo
Cotner, Howard, Altus
Cowan, Ted, Tulsa
Craighead, David, Midwest City
Cullison, Robert, Tulsa
Cummings, James, Crescent
Cunningham, Oval, Bristow
Davis, Don, Lawton
Davis, Guy, Calera
Denman, Don Curry, Oklahoma City
Duckett, Ross, Mustang
Duke, Don, Ardmore
Dunn, Vernon, Loco
Edmondson, W. A., Muskogee
Elder, Charles, Purcell
Ervin, William, McAlester
Ferrell, Fred, Jr., Elgin
Fitzgibbon, Joseph, Miami
Floyd, Glenn, Norman
Ford, Charles, Tulsa
Frates, Kent, Oklahoma City
Fried, Jim, Oklahoma City
Green, Warren, Tulsa
Hammons, Mark, Yukon
Hardesty, Jim W., Sperry
Harper, Bob, Frederick
Hastings, Joan King, Tulsa
Henry, Charles, Shawnee
Hibdon, Mina, Norman
Holaday, T. W. Bill, Oklahoma City
Holt, James, Ponca City
Hooper, Roy B., Jr., Lawton
Hopkins, Robert, Tulsa

Johnson, Joe A., Heavener
Johnson, Don, Pawnee
Johnston, Jeff, Seminole
Joiner, Fred, Del City
Kamas, Lewis, Freedom
Kane, Robert, Bartlesville
Kardokus, James, Apache
Kennedy, Billy, Pawhuska
Kilpatrick, Don, Del City
Lancaster, Bill, Wagoner
Manning, Joe, Jr., Cushing
Matheson, Mandell, Tulsa
McCaleb, Neal, Edmond
McIntyre, Bernard, Tulsa
McKee, Marvin E., Guymon
Miskelly, John, Jr., Choctaw
Monks, John, Muskogee
Morgan, Charlie, Prague
Murphy, Mike, Idabel
Parris, Bob, Sallisaw
Payne, Gary, Atoka
Peterson, Charles, Checotah
Riggs, M. David, Tulsa
Roberts, Hollis, Hugo
Robinson, Bill, Holdenville
Rogers, Tom, Enid
Sanders, E. C. Sandy, Oklahoma City
Shotts, Ron, Moore
Sparkman, Wiley, Grove
Stephenson, Tom, Watonga
Stratton, David, Clinton
Swinton, Judy, Oklahoma City
Thornhill, Lynn, Wakita
Townsend, James, Shawnee
Twidwell, Carl Jr., Spencer
Vaughn, George, Big Cabin
Weichel, Jerry, Colony
Whorton, J. D., Pryor
Wickersham, Victor, Mangum
Willis, William, Tahlequah
Wilson, Robert, Duncan
Wiseman, William, Tulsa

NAY

Johnson, A. Visanio, Oklahoma City
Nance, Kenneth, Oklahoma City
Thompson, Donald, Sapulpa

EXCUSED

Atkins, Hannah, Oklahoma City
Briscoe, Bill, Claremore
Draper, Daniel D., Jr., Stillwater
Holden, A. C., Dewey
Hood, David C., Oklahoma City
Poulos, William, Tulsa
Prentice, Charles, Tulsa
Smith, Jerry L., Tulsa

SENATE ROLL CALL
on SB 622

AYE

Baldwin, Don, Anadarko
Berrong, Ed, Weatherford
Birdsong, Jimmy, Oklahoma City
Boatner, Roy A., Calera
Butler, Kenneth, Okmulgee
Cate, Lee, Norman
Crow, Herschal, Altus
Dahl, John L., Barnsdall
Dawson, Bill, Seminole
Field, Leon B., Texhoma
Funston, Bob, Broken Arrow
Garrett, John, Del City
Grantham, Roy, Ponca City
Graves, Ralph, Shawnee
Ham, Glen, Pauls Valley
Hamilton, James, Poteau
Helm, Mary, Oklahoma City
Holden, Wayne, Duncan
Howard, Gene, Tulsa
Howell, James, Midwest City
Inhofe, James M., Tulsa
Keating, Frank, Tulsa
Keller, E. W., Oklahoma City
Lamb, Norman, Enid
Lane, Jim E., Idabel
Luton, John D., Muskogee
McCune, John, Oklahoma City
Martin, Ernest D., Ardmore
Medearis, Robert, Tahlequah
Murphy, Robert, Stillwater
Pierce, Jerry T., Bartlesville
Randle, Rodger, Tulsa
Schuelein, William, Miami
Shatwell, Bob, Tulsa
Taliaferro, Jim, Lawton
Terrill, Al, Lawton
Tinsley, Gideon, El Reno
Wadley, Robert, Claremore
Watkins, Wes, Ada
Watson, Phil, Edmond
Wolfe, Stephen, Tulsa
York, Marvin, Oklahoma City

NAY

Porter, E. Melvin, Oklahoma City

EXCUSED

Capps, Gilmer N., Snyder
Lambert, Phillip, Oklahoma City
Young, John W., Sapulpa
Smith, Finis W., Tulsa
Stipe, Gene, McAlester

MEDICAL HERITAGE COMMITTEE

Your Medical Heritage Committee has been charged with the responsibility of preserving, through papers and artifacts, the medical history of our state. Over the past few years, we have accumulated a large quantity of artifacts and documents. A few of these items are on display in the lobby of the OSMA Headquarter's Building in a display case purchased by the committee some years ago.

The remainder of the items collected are currently in storage in either the OSMA Headquarter's Building or the Stovall Museum on the OU Campus at Norman. It is hoped that some day we can use these artifacts in a medical history museum in our state. In the meantime, your committee is attempting to find other locations for displaying the artifacts collected thus far. It is possible that we may be able to assist the Cowboy Hall of Fame with its Doctor's Office Display in the near future.

In searching for display locations, we are constantly faced with a refusal based on "lack of space." Many times the possible exhibit locations have requested photographs as opposed to books, instruments and other artifacts.

Although your committee has a large collection of materials, it has a very limited number of photographs. Because photographs are the most popular display items, the committee would like to issue an appeal to all OSMA members and Auxiliary members to help it search out and collect early medical photographs.

In the meantime, your committee will continue to search for new display locations.

Supplement to the report of the COUNCIL ON PUBLIC POLICY April 10, 1976 *(APPROVED)*

The Council on Public Policy would like to commend Don Blair, OSMA executive director, and David Bickham, OSMA associate executive director, for their outstanding dedication and service during the past year.

These two men have worked diligently since our last Annual Meeting to maintain the highly revered reputation of the Association and to insure the future of the profession in this state.

Although many were involved at various levels, a special thanks must go to Mr. Blair for his painstaking work and leadership in developing a model utilization review plan which will benefit the doctors, the hospitals, and the public of this state. Without his assistance and leadership, this project could not have been completed.

The Council's sincere gratitude also goes to Mr. Bickham for his exemplary work at the Legislature. Mr. Bickham's untiring efforts led to the overwhelming passage of SB 622 which will provide the membership much needed relief from the many problems in professional liability.

The Council and the Association owe a debt of gratitude to these two men.

Report of the COUNCIL ON PROFESSIONAL AND INTERVOCATIONAL RELATIONS April 10, 1976 *(APPROVED)*

Council Members

Marion C. Wagnon, MD, Chairman, Del City
Frank W. Clark, MD, Ardmore
Floyd F. Miller, MD, Tulsa
Fred W. Sellers, MD, Mangum
Donald F. Rhinehart, MD, Oklahoma City
Norman A. Cotner, MD, Grove
Bryce O. Bliss, MD, Tulsa
Marvin K. Margo, MD, Oklahoma City
David P. Mitchell, MD, Madill

SECTION I INTRODUCTION

It is this Council's responsibility to maintain the ongoing liaison with professional organizations that have an interest in medical affairs and with allied organizations that assist us in our various medical efforts. While the Council itself has not been very active this year, the liaison between the various organizations has continued as the report will indicate.

SECTION II MEDICAL-LEGAL RELATIONS

For many years the Medical-Legal Commit-

tee, a joint committee of the Oklahoma Bar Association and the Oklahoma State Medical Association have sponsored a Medical-Legal Seminar every two (2) years. After discussing the matter in some detail at a meeting this year, the Committee has decided to discontinue the regularly scheduled Medical-Legal Seminars. The associations do wish to keep the committee organized and active and will find other ways in which to provide information about the two professions to doctors and lawyers.

SECTION III
MEDICAL-DENTAL RELATIONS COMMITTEE

The Medical Association and the Dental Association have worked closely together during the last two (2) sessions of the legislature to coordinate the lobbying efforts of both groups. Frank Stewart, DDS, a Dental Association representative, sits on OSMA's Legislative Committee as an ex officio member and organizes the Dental Association's legislative efforts so that they coincide with the Medical Association's.

Several issues this year have affected the two professions, most notably the original proposal of the Governor to reorganize the Executive Branch of the government in such a manner that it would have probably eliminated the autonomous licensing boards of medicine and dentistry. With the help of other health groups we were successful in having this portion of the Governor's reorganization plan either delayed, altered or perhaps set aside completely. Another significiant legislative matter that affected both professions was the omnibus medical malpractice bill, SB 622. Dentists statewide were asked to contact their Senator and Representative in support of the bill and the results, of course, were very good.

SECTION IV
OPHTHALMOLOGY and OPTOMETRY

Last year the Council reported on a lawsuit that had been filed by the Board of Optometric Examiners on a dispensing optician in Shawnee that had resulted in a court ruling, that, among other things, would prohibit opticians from using a keratometer or ophthalmometer. The District Court found in favor of the optician but the Court of Appeals overruled the lower court's decision. However, on appeal to the Supreme Court on the basis of a supporting Amicus Curiae Brief prepared by OSMA Legal Counsel, Roy Lytle, the Supreme Court ruled in favor of the optician. The case was appealed by the Board of Optometric Examiners, but the appeal was denied. The net result then is that the long established relationship between ophthalmologists and opticians has not been impaired. It appears that this matter has been resolved completely in our best interests.

SECTION V
OCCUPATIONAL MEDICINE

The Occupational Medicine Committee has been active this year in working with the Governor's Commission on Workmen's Compensation in an effort to reform Oklahoma's antiquated Workmen's Compensation Act. David Bickham, Associate Executive Director of the Association was named by Governor Boren to serve on the Commission which had representatives from industry, labor, insurance, legislative and medicine. After four months of intensive study and public hearings, the Commission recommended to the legislature, an omnibus bill which, if enacted, would have satisfied seventeen of the nineteen federal requirements on Workmen's Compensation. It is, in the view of most observers, a very fair and equitable bill for all the parties concerned, especially the injured worker. Doctors Carl, Blaschke and Nelson testified before the Commission on the medical aspects of Workmen's Compensation and recommended for inclusion in the bill that a medical panel be established to review cases in which there was a wide divergence of medical opinion and also that the injury rating be designated by "impairment of function" rather than percentage of disability. These provisions were included in the proposed legislation.

Unfortunately, a powerful labor union objected to substantial portions of the bill and through some questionable legislative maneuvering, it is doubtful that any Workmen's Compensation reform will be passed during this session of the Legislature.

SECTION VI
GENERAL

In addition to the previously mentioned rela-

tionships, the Association maintains a continuing liaison with the Oklahoma Nurses Association by virtue of our Doctor of the Day program. OSMA staffs the First Aid Station each day with a volunteer nurse.

The Council still maintains Claimsmen Liaison Committee, but no formal meetings have been held this year.

RECOMMENDATIONS:

This is an informational report to the House of Delegates.

Report on the
COUNCIL ON SOCIOECONOMIC ACTIVITIES
April 10, 1976
(*APPROVED*)

Council Members

Roger J. Reid, MD, Chairman, Ardmore
Walter E. Brown, MD, Tulsa
Howard B. Keith, MD, Shattuck
Robert R. Dugan, MD, Oklahoma City
Leon N. Gilbert, MD, Bethany
Ann K. Kent, MD, Muskogee
Roger Haglund, MD, Tulsa
Ed L. Calhoon, MD, Beaver
Robert Sukman, MD, Oklahoma City
Kenneth L. Evans, MD, Kingfisher

Peer Review Committee "A"

Tony Puckett, MD, Chairman, Oklahoma City
Jack L. Richardson, MD, Tulsa
Robert M. Shepard, Jr., MD, Tulsa
Frank L. Adelman, MD, Enid
Samuel A. Wheeler, MD, Oklahoma City
Bobby Gene Smith, MD, Oklahoma City
John A. McIntyre, MD, Enid
Joseph N. Kramer, MD, Oklahoma City
George R. Jay, MD, Oklahoma City
Tom C. Sparks, MD, Ardmore
Roger Haglund, MD, Tulsa
Leonard H. Brown, MD, Tulsa
William R. McShane, MD, Tulsa
Robert G. Small, MD, Midwest City
Clarence Robison, Jr., MD, Oklahoma City
Gerald W. McCullough, MD, Norman
Martin R. Hullender, Jr., MD, Altus
Earnest R. Daffer, MD, Oklahoma City

Peer Review Committee "B"

Arthur E. Schmidt, MD, Chairman, Oklahoma City
Joseph Salamy, MD, Tulsa
William E. Hood, Jr., MD, Oklahoma City
Neil B. Kimerer, MD, Oklahoma City
David D. Rose, MD, Ardmore
Leon Combs, MD, Shawnee
Alfred H. Bungardt, MD, Tulsa
Thomas Henley, MD, Oklahoma City
Bill B. Henley, MD, Lawton
Ron Barlow, MD, Oklahoma City
S. Fulton Tompkins, MD, Oklahoma City
Richard M. Taliaferro, MD, Ada
William J. Forrest, MD, Oklahoma City
David B. Brinker, MD, Oklahoma City
Schales Atkinson, MD, Oklahoma City
Fred D. Switzer, MD, McAlester
Martin Stokes, MD, Ada
James B. Thompson, MD, Tulsa

Peer Review Consultants

Robert Morgan, MD, Oklahoma City
Kent Braden, MD, Oklahoma City
Robert L. Imler, Jr., MD, Tulsa
William B. Renfrow, MD, Oklahoma City
Thomas L. Ashcraft, MD, Tulsa
Michael H. Berkey, MD, Tulsa
Neil Woodward, MD, Oklahoma City
Billy R. Goetzinger, MD, Oklahoma City
Warren L. Felton, MD, Oklahoma City
Ronald C. Elkins, MD, Oklahoma City
Lyle W. Burroughs, MD, Oklahoma City
Charles J. Wine, MD, Oklahoma City
A. Manson Fuller, MD, Tulsa
Gerald W. Boles, MD, Oklahoma City
James E. Mays, Jr., MD, Oklahoma City
Edward R. Munnell, MD, Oklahoma City

SECTION I
INTRODUCTION

The biggest responsibility of the Council on Socioeconomic Activities is its Peer Review functions which are conducted by two Peer Review Committees.

Other socioeconomic activities involving the council have primarily to do with third-party relationships, practice advice for young physicians and some socioeconomic aspects of medical practice for physician office personnel.

The Council on Continuing Medical Education ran a survey of physicians two years ago that indicated the need for some instruction in various business aspects of medical practice. OSMA Associate Executive Director Ed Kelsay developed such a course and conducted a

series of lectures across the State which were extremely well received. There have been requests to renew this membership service.

The House will consider some reorganization of OSMA Councils and Committees and it is anticipated that this function will be handled by a new council on medical service (if the reorganization plan is approved in the future).

One of the principal activities of the Council in past years has been its ongoing liaison with the various insurors of health care services. Because of the very active nature of the two Peer Review Committees, most of these relationships have been handled by those committees as will be seen by the reports to follow.

SECTION II
PEER REVIEW COMMITTEE

For ten years the Medical Association has had an active Peer Review Committee to aid in the adjudication of the problems between physicians and patients and conversely, physicians and insurors; and other third party intervenors. The Peer Review mechanism, originally called Medical Insurance Review, has worked extremely well. In 1969, the House of Delegates formalized the Peer Review process and shortly thereafter a written Peer Review procedure was published and publicized to Association members.

The work of the Committe has grown considerably over the years. In 1969, the Committee reported that during the past three years, 167 cases had been referred for adjudication, or an average of 54 cases a year. In 1971, the Committee heard a total of 93 cases. In 1974, the Committee reviewed 168 cases and in 1975-76 organizational year the Commmittee will review over 500 cases. A portion of this increased workload can be attributed to a new law, HB 1181, passed in the First Session of the 35th Legislature, that requires the processing of health insurance claims within a thirty (30) day period. The new law, thought to be a boon to physicians and patients at the time of passage, has created quite an administrative problem for the Peer Review Committees. A literal interpretation of the Act requires that a policy holder's claim for payment be paid within thirty (30) days after receipt of the claim or that he be notified by certified mail if for some reason the claim cannot be paid. In the event no notification is given, then the lack thereof is considered prima facie evidence that it will be paid. The real impact of this new law is evident in the resolution of disputed "usual, customary and reasonable" fee insurance plans. If, after processing the claim, the physician's billed charges exceed the insurance company's prevailing fees, and a satisfactory settlement cannot be made between the insurance company and the physician, and if the case is to be forwarded to the Peer Review Committee, then under an interpretation of the law, the patient would have to be notified that the physician's charges are in excess of the insurance company's prevailing fee determination. Rather than have the insurance company imply that a physician had, in fact, overcharged his patient, it was the committee's decision that we would adjudicate such cases if the insurance company would pay the prevailing fee and if the physician was given the option of referring the case to the Committee. The net result has been that when the physician receives notification from the insurance company that his fee is above the company's prevailing profile, and that he has an opportunity to refer his case to the Committee, then it is almost routinely referred regardless of the amount of money involved.

Representatives of the Committee have been working very carefully with representatives of the insurance industry in trying to alleviate the situation and it is anticipated that in the very near future, procedural changes will be made in the Peer Review process to reduce the number of cases being referred.

The Committee would like to make a special point to the House of Delegates that the policy under which we operate was established by the Association's House of Delegates in its usual, customary and reasonable charge concept. Apparently, previous decisions of the House have established the position that the Association has a responsibility to its members to make certain that they are not taken advantage of by third party payors and at the same time have stated that physician members of the Association are responsible to their colleagues for not overcharging their patients. The Committee has adopted the theory that it does not wish to interfere in the physician-patient relationship, and if a physician discusses with his patient a charge prior to the rendering of a service, and if the patient is satisfied with the charge, then the committee

has no responsibility in that relationship except to establish for the third party payor what is usual, customary and reasonable for a similar service, which, in effect, would limit the liability of the carrier.

Almost all of the physicians who have cases referred to the Committee honor the decision of the Committee as do the carriers that refer cases to the Committee. However, in recent months, probably due to the increased number of cases referred as a result of HB 1181, there are some members that feel that they are above the decision of the Committee. At the present time, we do not think that these isolated few cases require any definite action by the Delegates.

A few cases are being referred to the Committee that enter into the area of quality care determinations. These have been handled in the most appropriate manner possible after consulting with the county medical societies and the various consultants that advise the Committee. On at least one occasion, it has been necessary to refer a case to the Grievance Committee, which is one of the responsibilities of the Committee.

While it is necessary for the Association to honor its public and membership responsibilities for adjudication of unusual medical claims, it is doubtful that the founders of the Peer Review process envisioned the significant time and financial sacrifices required by the members of the Association who serve on the Peer Review Committee. Probably, few of the members realize that Committee members meet every other month, have considerable homework to do before they attend, and spend from 4-6 hours on Sunday afternoon reviewing claims that are referred by their colleagues. Thirty-three percent of the cases reviewed by the Committee in recent months have been for amounts of $50.00 or less. Again, we think that this problem will work itself out, but before a physician member of the Association submits a claim for review, he should carefully check his coding and billing procedure.

Conservatively speaking, it costs an average of $62.25 to review each claim, which only includes the physician's volunteered time and a modest mileage allocation.

For your information, we are attaching hereto, a copy of the Peer Review Functions and Enrolled HB 1181, which has created some of the problems.

RECOMMENDATIONS:

This is an informational report to the House of Delegates and as mentioned earlier, the previous policy established by the Association permits the Committee to make certain procedural changes to alleviate some of the problems mentioned in this report.

PEER REVIEW FUNCTION

I. PURPOSE:

The Peer Review Committee of the Oklahoma State Medical Association, and similar committees created by component societies of the state association, shall serve the function of seeking the objective reconciliation of unusual medical insurance claims involving members of the OSMA and health insurance coverages which offer payment of customary and reasonable fees.

II. ORGANIZATION:

OSMA Committee: The state association committee, to be appointed annually by the President, shall be comprised of a chairman, two vice-chairmen and at least twenty additional members selected geographically and by type of practice.

The committee shall be divided into two subcommittees of equal size. The subcommittees will meet on alternate months.

Quorum: A vice-chairman shall preside over each meeting. A simple majority of subcommittee members shall be required before any decision may be made by a subcommittee.

III. REVIEW PROCEDURES:

A. *Conditions Prerequisite to Peer Review:* The following conditions must be met prior to a case being submitted for peer review;

1. Other appropriate avenues of settlement must have been attempted by the carrier directly with the physician prior to requesting peer review, including either correspondence or telephone consultation, or personal visitation.

2. The patient (if applicable) and the physician, (in every case) should be advised in writing by the carrier that there will be an administrative delay in final settlement of the claim. The letter to the patient should not include the statement that a review of charges or utilization is in process, but the physician should be advised by the carrier that the unusual nature of the claim requires its sub-

mittance for review by the Peer Review Committee.

3. A "Peer Review Summary" form, five complete sets of the claim forms in question and any other necessary medical record information should be furnished to the OSMA Peer Review Committee, 601 NW Expressway, Oklahoma City, Oklahoma 73118.

IV. REVIEW PROCESS:

1. When a properly filed and documented case is received the OSMA shall immediately schedule it for a specific hearing date, provided that cases received less than fifteen days (excluding weekends) prior to the next scheduled meeting shall be deferred to the meeting scheduled for the following month.

2. Upon receipt of a case to be reviewed, the physician involved and the chairman of the county society review committee where the physician resides shall be notified. Both shall be furnished complete copies of the material which has been provided in documentation of the case, and both shall be invited to attend the subcommittee hearing. The county society review committee shall be invited to furnish a written opinion for consideration by the state committee.

3. In addition to hearing and taking action on cases filed by carriers or insurance companies, the Peer Review Committee shall also receive cases filed by a member of the association against a carrier or company, and cases by a patient against a physician.

4. The committee shall have the obligation of finding in favor or against the amount of charges or the quantity and/or medical necessity of the services provided. In each claim reviewed the state committee has the obligation of recommending a reasonable settlement.

V. RECIPROCAL RESPONSIBILITY:

The OSMA Peer Review Committee can only be effective if its decisions are honored by the organizations or persons who are directly involved in the adjudication of questioned claims.

VI. DISCIPLINARY JURISDICTION:

The Peer Review Committee of the OSMA shall not function as a disciplinary body, but it does have the obligation to file charges with the association's Grievance Committee, or Board of Censors of a county medical society, when warranted by the circumstances of a particular case involving the conduct of an association member.

OSMA PEER REVIEW COMMITTEE OPERATING PROCEDURE

The following is the Operating Procedure for handling cases submitted to the OSMA Peer Review Committee.

Upon receipt of a completed Peer Review Summary form and appropriate documents, the following actions will be taken:

1. Receipt of the case will be acknowledged to the sender.

2. The case will be scheduled for hearing at the next subcommittee meeting date (provided that at least 15 working days intervenes between the scheduling of the case and the meeting date . . . 45 days in the event the case involves a Tulsa or Oklahoma City physician.)

3. The physician (or carrier) involved will be notified that a case has been received, informed of the hearing date, forwarded a copy of all materials received, and invited to submit any comments that might aid the committee in arriving at an equitable finding.

4. A copy of all materials will be forwarded to the Peer Review Committee of the county society where the physician is a member. The society committee will be notified of the meeting date and be invited to give an opinion for consideration by the state committee.

5. A copy of the entire case (all documents) will be sent to one member of the appropriate subcommittee for an in-depth advanced review. An attempt will be made to see that the advanced reviewer is of the same specialty as the physician involved.

6. Approximately two weeks prior to the meeting, all members of the appropriate subcommittee will be sent copies of the summary forms of all cases to be heard on the meeting date. This will allow them to familiarize themselves with each case before the hearing day.

7. On the hearing date the advanced reviewer will present an in-depth explanation of the case and his findings to the committee.

As soon after the meeting as possible, the OSMA staff will prepare decision letters for the carrier and physician involved.

AN ACT

Enrolled House Bill No. 1181

By: CAMPBELL AND BAMBERGER of the HOUSE and YOUNG of the SENATE

AN ACT RELATING TO INSURANCE: REQUIRING A WRITTEN EXPLANATION FROM INSURERS WHEN PAYMENT OF CLAIMS IS DELAYED: PROVIDING FOR ATTORNEY'S FEES IN CASES OF LITIGATION; PROVIDING THAT THE VIOLATION OF ANY OF THE PROVISIONS OF TITLE 36, ARTICLE 12, IS AN UNFAIR TRADE PRACTICE; DIRECTING CODIFICATION; AND DECLARING AN EFFECTIVE DATE.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1 In the administration, servicing or processing of any individual, group or blanket accident and health insurance policy, it shall be an unfair trade practice for any insurer to fail to notify a policyholder in writing of the cause for delay in payment of any claim where said claim is not paid within thirty (30) days after receipt of proof of loss; the notification shall be by certified mail return receipt requested. Failure to provide the insured or the assignee of record with such notification shall be prima facie evidence that the claim will be paid in accordance with the terms of the policy. Provided that in the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney's fee to be set by the court and taxed as costs against the party or parties which do not prevail.

SECTION 2. Section 1 of this act shall be codified in Title 36, Article 12, of the Oklahoma Statutes.

SECTION 3. This act shall become effective October 1, 1975.

Report of the
COUNCIL ON PUBLIC HEALTH
April 10, 1976
(APPROVED)

Council Members

Schales L. Atkinson, MD, Chairman, Oklahoma City
Glen L. Berkenbile, MD, Muskogee
C. Thomas Thompson, MD, Tulsa
Hayden H. Donahue, MD, Norman
R. LeRoy Carpenter, MD, Oklahoma City
Nolen Armstrong, MD, Oklahoma City
Samuel Wheeler, MD, Oklahoma City
Charles Smith, Jr., MD, Oklahoma City
Norman L. Haug, MD, Oklahoma City
Donald Cooper, MD, Stillwater
Dan Keller, MD, Oklahoma City
Armond Start, MD, Oklahoma City
Jim H. Earls, MD, Oklahoma City

Alcoholism and Drug Abuse Committee

Jim H. Earls, MD, Chairman, Oklahoma City
E. Edwin Fair, MD, Ponca City
Thomas M. Donica, MD, Oklahoma City
Alfonso Paredes, MD, Oklahoma City
Pamela R. Parrish, MD, Oklahoma City
V. M. Rutherford, MD, Midwest City
Nolen Armstrong, MD, Oklahoma City
J. Hartwell Dunn, MD, Oklahoma City
Donald Cooper, MD, Stillwater
Ray V. McIntyre, MD, Kingfisher
J. R. Drumwright, MD, Bartlesville

Immunization Committee

Armond H. Start, MD, Chairman, Oklahoma City
William L. Edwards, MD, Duncan
R. LeRoy Carpenter, MD, Oklahoma City
Burdge F. Green, MD, Stilwell
Ralph E. Murphy, MD, Ardmore
James E. Mays, Jr., MD, Oklahoma City
John C. Kramer, MD, Tulsa
Harris D. Riley, Jr., MD, Oklahoma City
Delmar Gheen, Jr., MD, Tulsa
George Prothro, MD, Tulsa
Quellen M. Hughes, MD, Del City
Y. E. Parkhurst, MD, Miami

Maternal Mortality Committee

Schales Atkinson, MD, Chairman, Oklahoma City
James A. Merrill, MD, Oklahoma City
Max Deardorff, MD, Tulsa
Sara DePersio, MD, Oklahoma City
Paul A. Bischoff, MD, Tulsa
E. E. Blackwood, DO, Oklahoma City
Matthew B. Moore, MD, Tulsa
Jed Goldberg, MD, Tulsa
J. W. McDoniel, MD, Chickasha
Frank Barnett, MD, Midwest City

Laboratory Quality Committee

Dan Keller, MD, Chairman, Oklahoma City
Byron Smith, MD, Oklahoma City
Bryce O. Bliss, MD, Tulsa
Robert Alexander, Jr., MD, Okmulgee
Bill E. Blevins, MD, Midwest City

John F. DeJarnette, MD, Ponca City
M. Boyd Shook, MD, Oklahoma City
Dale VanWormer, MD, Tulsa
J. William Hood, MD, Oklahoma City

Emergency Medical Services Committee

Arthur F. Elliott, MD, Chairman, Oklahoma City
Harry B. Tate, MD, Oklahoma City
Gerald E. Gustafson, MD, Tulsa
Gerald McCullough, MD, Norman
Barney J. Limes, MD, Oklahoma City
Kenneth Evans, MD, Kingfisher

SECTION I
Introduction

Due to a decrease in association staff, substantial time commitments to federal and state government activities, the Council on Public Health has been rather dormant this year. Normally, the various committees are very much involved in areas ranging from Alcoholism and Drug Abuse to monitoring the performance of physicians' office laboratories. Many of the routine activities of the Council continued throughout the year as the following reports will indicate.

SECTION II
Committee on Alcoholism and Drug Abuse

The alcoholism and drug information campaign carried out by the Association two years ago, and the Association-developed "Drug Abuse Treatment Manual" updated and distributed last year, resulted in a continuing demand by schools and various health agencies for additional information. The Association maintains a limited quantity of literature for distribution on request and occasionally arranges for speakers on Alcoholism and Drug Abuse.

Legislation passed two years ago has resulted in required courses on drug abuse in the public school system, whether this program has or is being successful remains to be seen. Another law that passed last session probably has had more impact than the required education act, HB 1537, provided minors the right to consent for medical treatment without parental consent. Sponsors of the bill testified that studies showed that minors in trouble with drugs or alcohol were deterred from seeking medical help or counseling because they were afraid their parents would find out about the problem. The new law leaves the matter of advising parents to the discretion of the treating physician. There is currently an effort being made by the Sanity on Sex organization to have the law repealed or modified. Their concern is that physicians will indiscriminately prescribe birth control pills to sexually active teenagers without notifying parents. The Association has had no complaints regarding abuses of the law.

SECTION III
Committee on Immunization

Each year the Immunization Committee reviews the recommended immunization schedule published by the state health department and revises the schedule as deemed necessary. Revised copies are distributed to all physicians in the state and to hospitals. This year's schedule was printed on heavy stock paper with bright yellow trim so as to attract attention. It has been mailed, additional copies are available through the State Department of Health.

President Gerald Ford requested an appropriation of 135 million dollars to carry out a massive flu immunization campaign. With recent approval of the bill assured, Health Department Officials have started planning the vaccination campaign. There are a considerable number of problems to be resolved, especially availability, the new vaccine is not expected to be marketed until late summer.

The President's plan is to have the entire country inoculated before winter. Armond Start, MD, State Epidemiologist, will be in charge of the project and has indicated that he will ask the asociation for assistance in completing the project.

SECTION IV
Maternal Mortality Committee

Your Committee has continued to be very active in reviewing the maternal deaths reported to the State Health Department. Physicians are again encouraged to reply promptly to the maternal mortality committee's request for information about the maternal deaths. It is in this manner that we are able to isolate potential problems and prescribe corrective ac-

tion. The majority of physicians do honor our requests for reports, but we would appreciate prompt attention in filling out the necessary forms.

The findings of the committee are of course confidential and the purpose is purely scientific, and no information provided by physicians is released to anyone other than committee members. Because the committee had to delay its most recent meeting, we were not able to provide the compiled statistics as we have done in the past. Hopefully, we will be able to publish an article for the OSMA *Journal* in the near future giving the Oklahoma statistics.

There is considerable public concern about recent deaths connected with persons who are members of the Church of the First Born. State law does provide that legal authorities can overrule objections and permit the rendering of medical services to a member of a religious group, over the objections of others when that person is in no condition to consent for the medical services themselves. The committee recognizes that religious freedom is a constitutionally guaranteed right and casts no dispersion on any individual's prerogative to follow their religious beliefs. It is unfortunate, to say the least, and seems unrealistic that persons would permit the death of a child or other loved one for the sake of religious beliefs.

SECTION V
Committee on Laboratory Quality

The committee continues to offer a program to Oklahoma physicians that provides for sample testing of office laboratory procedures. The Laboratory Quality Control Program was developed by the American Academy of Pathologists and Oklahoma physicians continue to be one of the largest groups enrolled.

SECTION VI
Emergency Medical Services Committee

Last year, your committee supported a state question that would have amended the constitution of Oklahoma to permit the organization of Emergency Medical Service Districts. Had the act passed, it would have permitted groups of counties to organize themselves and vote a tax levy to support the Emergency Medical Services deemed appropriate for that particular district. The statewide vote was against the state question, although, the margin of loss was fairly narrow. A resolution currently pending in the state legislature (SJR 54) calls for an election on a similar state question.

Governor Boren has, on repeated occasions in his two years of office, indicated strong support for improved Emergency Medical Services in Oklahoma. By executive order, he created a state EMS and requested that physician nominees to the committee be submitted by the Medical Association. Gerald McCullough, MD, was appointed at the request of OSMA President, Arnold G. Nelson, MD. Doctor Arthur Elliott, Chairman of the Committee, attended DHEW and AMA sponsored seminars on EMS and continues to work in an active way with physicians interested in EMS.

It is anticipated that the activities of the committee will increase considerably during the next year, especially if the state question authorizing the creation of EMS Districts is passed. The Governor has indicated that he plans to reorganize the EMS Division of the State Health Department and put more emphasis on developing emergency services. He plans to use the state office of the Department of Transportation as the funding source for his program.

Special Report
of the
COUNCIL ON PUBLIC HEALTH
(APPROVED)

In the annual meeting of the House of Delegates of 1974, the Kingfisher County Medical Society sponsored a resolution that "RESOLVED: That the Oklahoma State Medical Association develop a standard college entrance physical form and promote its adoption for Oklahoma colleges and universities for both entering and transferring students." The Resolution was referred to this Council for a report to the Delegates.

The majority of the State's higher education institutions have developed their own health record form. The Council solicited a copy of the forms from a large number of the institutions to determine if standardization could be accomplished. We consulted with the Medical Directors of the Oklahoma State University and the Oklahoma University, and after meeting with the Chancellor of Higher Education and because there are only two institutions in the State who have full time Medical Directors, it is our suggestion that

(a) OSMA adopt the report of health history

and the report of health evaluation form developed and recommended by the Liaison Committee of the American College Health Association and the American Medical Association and approved by the American College Health Association as a standard entrance physical form for Oklahoma institutions of higher education; and

(b) That the Oklahoma State Medical Association keep on hand a quantity of the Medical History Physical Examination Record developed by Oklahoma State University and Oklahoma University to provide to Oklahoma physicians on request.

Resolution No. 1
(DISAPPROVED FOR SUBSTITUTE RESOLUTION)

INTRODUCED BY: Cleveland-McClain County Medical Society
SUBJECT: Environmental Quality
REFERRED TO: Reference Committee II

WHEREAS, constant pressure on environmental quality secondary to industrial and population growth rates continues in exponential fashion; and

WHEREAS, the health of the population of the state of Oklahoma is the primary concern of the Oklahoma State Medical Association; and

WHEREAS, technical, chemical and physical advances are being employed by industry daily; and

WHEREAS, the public health is so clearly related to pollution problems; and

WHEREAS, the Oklahoma State Medical Association believes in the quality of life; therefore be it

RESOLVED, that the Oklahoma State Medical Association take a leading position in the state of Oklahoma to protect the quality of environment and thereby the public health; that a full time environmental health specialist be retained; that the president of the association establish a six-man committee to work with the specialist and study the many issues and make recommendations to the association for positions on various environmental issues affecting the health of the public of our state; that an office be established in the state headquarters to which physicians could call and exchange information; and that the policies and positions established will leave no question that the protection of the health of the public is the primary concern, goal and objective of the Oklahoma State Medical Association.

(APPROVED SUBSTITUTE RESOLUTION)

INTRODUCED BY: Cleveland-McClain County Medical Society
SUBJECT: Environmental Quality
REFERRED TO: Reference Committee II

WHEREAS, constant pressure on environmental quality secondary to industrial and population growth rates continues in exponential fashion; and

WHEREAS, the health of the population of the state of Oklahoma is the primary concern of the Oklahoma State Medical Association; and

WHEREAS, technical, chemical and physical advances are being employed by industry daily; and

WHEREAS, the public health is so clearly related to pollution problems; and

WHEREAS, the Oklahoma State Medical Association believes in the quality of life; therefore be it

RESOLVED, That the President of the Oklahoma State Medical Association take a leading position in the State of Oklahoma to protect the quality of environment and thereby the public health, and a committee be appointed forthwith to study the many issues and make recommendations to the association and the public for positions on various environmental issues affecting the health of the public of our state.

Resolution No. 2
(APPROVED AS AMENDED)

INTRODUCED BY: Tulsa County Medical Society
SUBJECT: Voluntary American Medical Association Membership
REFERRED TO: Reference Committee I

WHEREAS, it is currently the policy of the Oklahoma State Medical Association to cause mandatory membership in the American Medical Associaton as a condition for membership in the Oklahoma State Medical Association; and

WHEREAS, this is felt to be an arbitrary and discriminatory practice; therefore be it

RESOLVED, that membership in the

American Medical Association be voluntary and not a precondition or condition to Oklahoma State Medical Association membership effective January 1, 1977; and be it further

RESOLVED, that the appropriate amendments to the Constitution and Bylaws of the Oklahoma State Medical Association be enacted to accomplish this purpose, and be it further

RESOLVED, that current dues paid for membership in the OSMA and AMA, remain the same in 1977 as in 1976 and that each member of OSMA be permitted, at the time of paying his dues, to indicate on the dues statement whether or not he wishes to belong to the American Medical Association, and be it further

RESOLVED, that the dues paid by the OSMA members who do not elect to become members of the American Medical Association shall be equitably apportioned between the county medical society and the State Medical Association on the basis of a formula to be established by the OSMA Board of Trustees.

Resolution No. 3
(DISAPPROVED)

INTRODUCED BY: David Browning, Jr., MD, Tulsa

SUBJECT: Continuing Medical Education as a Requisite for Relicensure of Physicians

REFERRED TO: Reference Committee II

WHEREAS, the medical profession of the State of Oklahoma has been and is actively involved in continuing postgraduate medical education; and

WHEREAS, the general public of the State of Oklahoma, as consumers of health care provided by physicians in this state, will wish to be informed and assured of the continuing education and competence of individual medical practitioners in the State of Oklahoma, as well as the medical profession as a group; and

WHEREAS, the Board of Medical Examiners of the State of Oklahoma by authority is responsible to the people of Oklahoma for assuring the continued competence of licensed physicians in Oklahoma; and

WHEREAS, continuing medical education is of vital importance to the continuing competence of practicing physicians in an age of progressive advances in medical knowledge; therefore be it

RESOLVED, that the Oklahoma State Medical Association shall resolve to the Board of Medical Examiners of the State of Oklahoma that the Association is in favor of organizing and documenting a continuing program of postgraduate medical education in the State of Oklahoma; the collection of data regarding individual participation in education programs by physicians in the State of Oklahoma; and the development of a program of mandatory participation in postgraduate medical education as a requisite for relicensure of each physician practicing in the State of Oklahoma, by the Oklahoma State Board of Medical Examiners, each three years; and be it further

RESOLVED, that the Oklahoma State Medical Association shall recommend to the Board of Medical Examiners that a joint liaison committee, including members of the Oklahoma State Medical Association and the Board of Medical Examiners, be appointed to determine and elaborate regulations for carrying out the administration of this program, and for submitting these regulations both to the Board of Medical Examiners of the State of Oklahoma, and to the Board of Trustees of the Oklahoma State Medical Association, for approval; and be it further

RESOLVED, that this joint liaison committee recommend the enactment of any state laws necessary as modifications to the current Acts of Medical Practice in the State of Oklahoma, as may be necessary for the implementation of the program.

Resolution No. 4
(TABLED)

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: Voluntary Association Membership

REFERRED TO: Reference Committee I

WHEREAS, the officers of many organizations tend to ignore a captive audience; and

WHEREAS, the American Medical Association has exhibited a considerable indifference to the desires and ideals of the average US physician; therefore be it

RESOLVED that the Oklahoma State Medical Association change its constitution to permit membership in the State and County Societies without mandatory membership in the American Medical Association, effective January 1, 1977.

Resolution No. 5
(REFERRED TO THE BOARD OF TRUSTEES)

INTRODUCED BY: Kingfisher County Medical Society
SUBJECT: Preservation of Quality Medical Care
REFERRED TO: Reference Committee II

WHEREAS, a political movement exists that would put all the population under a system of National Health Insurance; and

WHEREAS, National Health Insurance would inevitably lead to a general deterioration in the quality of medical care, and could easily be so expensive as to destroy the economic system of the United States; therefore be it

RESOLVED, that the Oklahoma State Medical Association respectfully requests the American Medical Association to adopt a policy against National Health Insurance and for the development of voluntary catastrophic health insurance by private insurance companies.

Resolution No. 6
(APPROVED AS AMENDED)

INTRODUCED BY: Perry A. Lambird, MD, Oklahoma City
SUBJECT: Talmadge Proposal For Salaried Hospital Based Physicians
REFERRED TO: Reference Committee II

WHEREAS, The proposals by Senator Talmadge to abrogate existing contracts between physicians and hospitals are antiethical to our free enterprise system, and;

WHEREAS, The Talmadge proposals, if incorporated into legislation, would substantially decrease the supply of physicians in specialty areas currently encountering significant shortages, and;

WHEREAS, The Talmadge proposals would have a significant adverse effect on patient care in hospitals through marked impairment of informal continuing medical education by hospital based physicians, and;

WHEREAS, The English experience has documented that placing physicians on salary does not provide a solution for either cost or quality problems extant on medical care, therefore be it

RESOLVED, That the Oklahoma State Medical Association go on record as opposing the Talmadge proposals WITH SPECIFIC REFERENCE TO HOSPITAL BASED PHYSICIANS and that this opposition be communicated to the members of the Oklahoma congressional delegation, to the Boards of Trustees of the American Medical Association and the American Medical Political Action Committee, and to the president of the College of American Pathologists, the American Society of Clinical Pathologists, the American College of Surgeons, the American College of Radiologists, the American Society of Anesthesiologists, the Council of Medical Staffs, the American Association of Physicians and Surgeons, and to the American College of Emergency Physicians, and the American College of Physical Medicine, the American Academy of Family Physicians, and to the presidents of such other organizations as the President of the Oklahoma State Medical Association deems appropriate, AND TO THE AMA HOUSE OF DELEGATES BY THE OKLAHOMA REPRESENTATIVES THERETO.

Resolution No. 7
(APPROVED AS AMENDED)

INTRODUCED BY: Washington-Nowata County Medical Society
SUBJECT: Professional Liability Cooperative
REFERRED TO: Reference Committee I

WHEREAS, Professional liability insurance has risen in cost and decreased in availability; and

WHEREAS, Only one company now writes professional liability insurance in Oklahoma; and

WHEREAS, The "ripple" effect of high premiums in surrounding states has escalated the size and number of judgments rendered there and in Oklahoma; and

WHEREAS, Professional liability insurance premiums may soon become so huge as to make private practice economically impractical to many physicians in Oklahoma; and

WHEREAS, Medical cooperatives are being established as a method for furnishing defense and protection of their members; and

WHEREAS, The medical cooperative may offer a viable alternative should medical liability insurance be unavailable for any reason; Therefore be it

RESOLVED, That the President of the

Oklahoma State Medical Association be directed to cause a thorough investigation of the existing medical cooperatives as well as the statutes of the State of Oklahoma relating to cooperatives; and be it further

RESOLVED, That tentative legal instruments and plans be presented to the Board of Trustees of the Oklahoma State Medical Association for approval and held in abeyance by that board, available for activation at such time as needed, and be it further

RESOLVED, That action be taken with the state legislature to obtain such legislation as necessary to permit activation of such a cooperative, and be it further

RESOLVED, That liaison be established with the Oklahoma State Hospital Association to assure that membership in such a cooperative will constitute adequate liability coverage for physician staff membership.

A BRIEF REVIEW OF THE MEDICAL COOPERATIVE PROGRAM

. . . for prospective members and other interested parties:

I. *Purpose:* The Cooperative is a non-profit effort initiated by doctors in an attempt to resolve their malpractice claims problems without governmental aid or interference. Economically as well as legally, the Cooperative is a group of individuals who elect to practice without professional liability insurance and to collectively share the economic consequences of this action.

II. *Organization:* The Cooperative is incorporated under state law as a doctors' cooperative. It will be governed by its member-elected Board of Directors. This Board is comprised exclusively of member doctors, and directs the activities of member committees as well as a professional administrative and legal staff employed by the Cooperative.

III. *Functions:* The Cooperative has the only program specifically designed to address the basic causes of malpractice claims:

a. Careful screening by elected peer groups and continued monitoring of participants (to limit negligent occurrences).

b. Early detection of incipient claims and provision for remedial medical services (to minimize lawsuits arising from real or imagined medical grievances).

c. Vigorous legal defense by the Cooperative's own attorneys against non-meritorious claims (to discourage nuisance suits based upon contingent-fee legal services).

d. Public education programs to inhibit unrealistic expectations by patients.

e. Payment of claims deemed meritorious by peer group committee and of court awards (limit $1 million per occurrence).

f. Support for further tort reform legislation.

IV. *Cost to Members:* The financial design of the Cooperative's Mutual Protection Trust includes creation of a bank-controlled trust fund into which each participating member will make a one-time, refundable deposit of $20,000. Legal costs and any claims payments will be made from the earnings issuing from investment of the trust fund; to the extent that such earnings may become insufficient for these liabilities in any future year, members will be assessed to cover the deficit. (Assessments will be adjusted to reflect the different risk categories of individual members' medical practice.) If earnings exceed claims costs, the surplus will be reinvested to further build the trust fund. Administrative and other related costs will be funded by annual membership dues. Delinquent payments will result in forfeiture of trust fund deposit and loss of coverage.

V. The trust fund principal will not be used to pay claims. Under the trust agreement, these funds cannot be released by the bank to anyone other than the original depositor members. Major banks have expressed their willingness to lend the $20,000 deposit to the Cooperative members (subject to individual credit review). Installment terms range up to five years, with fixed interest rates. Shorter term loans with floating interest rates are also available.

VI. *Entry Qualifications:* Membership in the Cooperative is open to any licensed MD who is affiliated with an accredited hospital, upon payment of an initial membership fee of $200. Member participation in the Mutual Protection Trust Program will require:

a. completion of the MPT application form and execution of MPT trust agreement.

b. acceptance by MPT peer group screening committee.

c. deposit of $20,000 into MPT bank-controlled trust fund. Membership in the Cooperative does not mean automatic participation in the MPT plan. Careful screening of applicants is necessary to protect all participating members in MPT.

VII. *Termination Conditions:*

a. *Disability:* legal and financial coverage continues without assessment, until able to resume practice.

b. *Retirement:* (at age 65 or over). Full coverage continues throughout retirement, without assessment. $20,000 will be refunded ten years from date of the original deposit.

c. *Death:* $20,000 will be immediately refunded to member's estate. The cooperative will purchase group term life insurance for this purpose. Full term coverage will be provided to protect the estate and survivors, without assessment.

d. *Voluntary terminations:* a member may withdraw $20,000 from trust fund (subject to ten-year minimum deposit requirement) and terminate, providing he is current on all assessments and is claims-free. Upon request, MPT will provide "tail" coverage at terminating member's expense, based upon actuarial determination of cost.

As an alternative, a member may elect to leave his deposit in the trust fund and continue paying his share of any assessments until the then-applicable statute of limitations period has expired, at which time $20,000 will be refunded and he will have no remaining liability.

QUESTIONS AND ANSWERS

1. Who will manage the Cooperative?

The Cooperative will be governed by a Board of Directors elected from the general membership. The Board will appoint and oversee peer group committees to conduct applicant screening and to review all claims against members. The Board will also supervise the bank administering the MPT trust fund and the legal staff. An executive director and a small staff will be hired to manage administrative matters.

2. Who will handle legal matters?

A law firm specializing in medical malpractice litigations will be available as needed to defend members on a reduced fee basis. As the case load grows, the internal legal staff will be expanded.

3. What is the Cooperative's position on arbitration?

The Cooperative supports any action which will limit professional liability claims and awards, and encourages its members to utilize arbitration procedures whenever possible.

4. Why is legislation needed to start the trust fund?

The statutes of Oklahoma need to be reviewed to see what, if any, legislation will be necessary to permit the establishment of this type trust fund.

5. What minimum membership is necessary to operate successfully?

With more than 400 members, the program would have enough for a viable cooperative although a much larger membership could be anticipated should the necessity for action of a cooperative in Oklahoma be deemed necessary.

6. Who will be screened out of participation in the MPT program?

Screening will be conducted by local committees with direct access to each applicant's hospital service record and professional history. The Cooperative wishes to exclude only those few individuals with a history of repeated medical negligence; (doctors who have been subjected to purely nuisance suits will not be automatically rejected.)

7. Why should all risk categories pay the same amount into the trust fund?

All participating members will be required to make a one-time deposit of $20,000 into the MPT fund and to pay uniform annual dues. Trust fund earnings and dues will be used to pay all the Cooperative's administrative and legal defense costs, which do not vary greatly by medical specialty.

If excessive awards make assessments necessary in future years, members will pay amounts which are graduated by their medical specialty (50% of average assessment for low-risk specialties; 100% for medium-risk; and 150% for high-risk members). This will fairly distribute any excess costs which result from larger claims payments in higher-risk categories.

8. Won't the Cooperative attract mostly high-risk doctors?

Cooperative membership is evenly divided at present with surgeons, anesthesiologists and other high-risk specialists representing approximately one-half and general practitioners, internists, and lower-risk physicians constituting the other half. The graduated assessment provisions recently instituted make the MPT program attractive to all categories of doctors.

9. What will prevent a catastrophic lawsuit from wiping out the Cooperative?

The MPT coverge limitation of $1 million per occurrence will prevent a single suit from jeopardizing the fiscal integrity of the coopera-

tive. With 1,000 members, the maximum payment would equate to an average of $1,000 per member. It should be remembered that there have been relatively few awards of this size in history. A much more serious problem is the rapid growth in the number of lawsuits, most of which are settled by insurance companies for relatively small dollar amounts. Cooperative action programs (screening, remedial services, vigorous legal defense) have been designed to combat this threat, while its payment limitation will protect the membership against a single high court award.

10. What happens if the Cooperative's financial reserves are depleted?

The MPT fund will never be depleted by claims payments; deposits into this trust fund will be held in trust by the controlling bank and released only as refunds back to members as specified below. Claims costs will be paid out only from the earnings accruing to the trust fund and, if necessary, by member assessment. With one thousand members, the trust fund will be fixed initially at twenty million dollars; with 5,000 members, the fund will be $100,000,000. Any earnings in excess of required claims payments will be re-invested to further build the trust fund.

11. How high can future assessments go?

The necessity for any future assessments can result only from aggregate claims costs which are in excess of trust fund earnings. If these costs are controlled, the likelihood of large assessments is remote; if the present runaway trend of malpractice costs continues, however, the resulting assessment could grow to a point at which the private practice of medicine will be destroyed. (This, incidentally, would also be the result for doctors carrying "claims-made" or occurrence insurance policies; instead of assessments, these doctors will face earlier annual or quarterly premiums which will be continuously adjusted to reflect claims experience.) There is, therefore, no available financial plan or insurance program anywhere which will enable doctors to escape the realities of the malpractice dilemma. An entirely different approach is necessary to combat this problem.

The Cooperative plan will provide doctors with an economic breather for a few years, during which the cooperative action programs (quality control through member screening, remedial claims handling, and vigorous defense against nuisance suits) as well as further tort reform, which is an eventual necessity, can go to work to reduce a malpractice cost burden which is presently unsupportable through conventional insurance channels.

The Cooperative offers the only program which is aimed at reducing the magnitude of malpractice, instead of merely attempting to shift the economic cost from doctors to some other group.

12. What if some members don't pay their share of assessments?

The MPT agreement is designed to protect participating members against losses caused by delinquent payment by other members. Failure to pay assessments will result in a loss of coverage for the delinquent member, forfeiture of the trust fund deposit, and no protection against future "tail" liability. In addition, the Cooperative has the legal right to sue for payment of the assessment if the membership and trustees decide to do so. With these sanctions, it is highly unlikely that there will be any significant delinquency, and the participating membership is further protected by the availability of forfeited trust fund deposits to compensate for unpaid assessments.

13. Won't the program collapse if a large number of doctors leave?

The MPT plan has been designed to avoid financial dilution caused by vacating members. The ten-year minimum deposit requirement enables the fund to earn enough to effectively replace the principal amount of any refunds, and the group life insurance policy will cover refunds to deceased members' estates. Any delinquencies can be paid out of forfeited trust fund deposits, as specified in the MPT agreement.

The objective of these provisions is to actually strengthen the fund when members depart, rather than deplete it.

14. What are the requirements for membership?

Any licensed MD in Oklahoma may join the Cooperative by paying the $200 initial membership fee.

To participate in the MPT program, a doctor must:

1. be a member of the Oklahoma cooperative.

2. be affiliated with an accredited hospital in Oklahoma.

3. complete the MPT application form and execute the MPT agreement which covers all rights and obligations.

4. be accepted by the MPT screening committee.

5. make a one-time deposit of $20,000 to the bank which will hold the fund in trust.

Membership in the Cooperative does not mean automatic participation in the MPT plan. Careful screening of applicants is necessary to protect all participating members. □

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The JOURNAL
of the Oklahoma State Medical Association

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CONTRIBUTIONS

Articles accepted for publication, including manuscripts of annual meeting papers, are the sole property of *The Journal* and must not have been published elsewhere. Authority for approval of all contributions rests with the Editorial Board, and the Board reserves the right to edit any material submitted. Manuscripts should be typewritten, double spaced and submitted in original and one copy. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned on request. *The Journal of the Oklahoma State Medical Association* is not responsible for the statements or opinions of any contributor.

STYLE

Footnotes, bibliographies, and legends for illustrations should be submitted on separate sheets, double-spaced. Bibliographies should follow in order of: name of author, title or article, name of periodical with volume number, page and date of publication. These references should be alphabetized and numbered in sequence.

ILLUSTRATIONS

Illustrations, other than the author's will not be accepted for publication unless accompanied by written permission to be reproduced. Illustrations should be identified by the author's name and the figure number of the illustrations. The illustrations should be numbered in the same order as referred to in the body of the article. Used photographs, and drawings will be returned after publication if requested. *The Journal* will pay for necessary black and white illustrations within reasonable limitations. The quality of drawings, sketches, etc., must be in keeping with the quality of the magazine.

NEWS

Members of the Oklahoma State Medical Association, the constituent societies of the association, and all readers in general are invited to supply news items of general interest to the profession.

ADVERTISING

All advertising copy must be approved by the Editorial Board before acceptance for publication. General and miscellaneous advertising rates will be sent on request.

EDITING SERVICE

The Editorial Board reserves the prerogative to submit contributions to a Medical Editing Service when warranted. If such is felt necessary, the Editor will contact the author for approval, informing him that there will be a modest charge for this service.

REPRINTS

Authors will receive reprint order forms from the Transcript Press, P.O. Drawer 1058, Norman, Oklahoma 73069, prior to final publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

BACK ISSUES

Microfilm copies of back issues of *The Journal* may now be purchased from University Microfilms, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

OSMA JOURNAL / *the last word*

The future of Oklahoma's only operational, federally-funded emergency medical system may very well depend on whether Governor Boren and the Department of Health, Education, and Welfare can work out their differences by the end of the fiscal year. If they cannot, the EMS system may very well go unfunded and thus will be phased out for at least a year.

The threatening controversy surrounding the EMS program seems to revolve around this year's switch of the program from the auspices of the Oklahoma State Health Department to the Oklahoma Highway Safety Department. Officials of DHEW say they question whether the transfer meets the guidelines of the 1973 law, and at this writing the funding for the program is still being held up. If the program is not funded by the June 30th cut-off date, the 24 county region included in the southeast EMS program will probably have to abandon its emergency system. Four hundred and seventy thousand Oklahomans live in that area of the state located south and east of I-40 and I-35 highways.

OSMA reorganization is now in the works with several councils being absorbed by new ones in an effort to streamline the organizational structure of the state medical association. In the 1976-77 year, nearly all OSMA business will be conducted by six major OSMA councils. Under the reorganization plan, the six operating councils will be: Member Services, Medical Services, Professional and Public Relations, Governmental Activities, Medical Education, and Public and Mental Health. Any OSMA member wishing to serve on any of these councils is invited to write Orange M. Welborn, MD, President, Oklahoma State Medical Association, 601 N.W. Expressway, Oklahoma City, Oklahoma 73118. If you would be willing to serve on more than one council, please list your preferences.

The United States Supreme Court has struck down a Virginia law barring advertising of prescription drug prices, saying commercial advertising is necessary for a well-informed public and is protected under the First Amendment of the Constitution. The Supreme Court ruling thus clears the way for advertising in an area which has before been barred. The immediate reaction of the ruling is mixed, with pharmacists predicting that it will pose a threat to the quality of medical care, and consumer advocates laying claims that it will work to lower the cost of medications and thus overall health care.

The AMA has filed a petition asking to join as a co-plaintiff in the North Carolina lawsuit against the federal government's National Health Planning and Resources Development Act. The North Carolina suit charges that the planning law's requirement that state legislatures pass "certificate of need" laws violates the Constitution by interfering with state government. The AMA further charges that the planning law interferes with the patient's right to freely seek the best care available, that the planning powers granted to HSA's are "contingent on sweeping control" of health facilities, and that such control violates rights to due process of law. The AMA said the authority given to HSA's to perform surveys of patients, without statutory restrictions, invades the privacy of the public.

The Tulsa County Medical Society has published a new 20-page booklet designed to assist new residents in that city in finding medical care. The booklet is being mailed to an average of about 200 new families each month which relocate to Tulsa. The guide contains information about how to use referral services of the county society and includes a listing of emergency care facilities, hospitals, and nursing homes. Also included is a listing of the 29 major medical specialties. The project was completed during the 1975 administration of E. N. Lubin, MD, who was President of the society at that time. A recent story in the Bulletin of the Tulsa County Medical Society reported "a flood of letters and telephone calls commending the society for the publication" has resulted. □

The JOURNAL of the Oklahoma State Medical Association

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Young men and women who seek life of service to mankind. Must be high school graduates, of good character, in good health and emotionally stable. Must be willing to finance eight years of formal education and sacrifice an additional two-to-five years in training for acquisition of special skills. During period of training, will work about one hundred hours per week and will earn the minimum hourly wage or less.

On completion of training period, graduates will begin two-to-four years of work as physician in an area designated by the federal government. These areas will be remote rural or wilderness areas of the United States or so-called urban ghetto areas in one of the larger cities. There will be no subsidies available and assignees will be responsible for finding, equipping and maintaining security for their own clinical facilities. They will also be responsible for finding, hiring and paying personnel essential to the operation of the facility and the provision of professional services. No arrangements will be made in consideration of the graduates' families or their social, educational and financial needs. No salaries or stipends will be available to graduates during this period of assignment. All remuneration will be earned and collected by the graduates themselves.

In lieu of the indentured service described above, graduates may elect to pay a fine or bondage-release-fee of approximately eight-thousand dollars to the federal government. If lump-sum payment cannot be made, it will be possible to work out periodic installment-payment schedules covering not more than four years.

Following the conclusion of the assigned service or payment of the fine as cited, graduates will be free to pursue the practice of medicine in whatever location they choose, provided they practice the kind of medicine determined to be needed in the area chosen, such determinations to be made by an appropriate authority of the federal government . . .

And provided they practice in accordance with the laws of the state in which they practice and all the rules, regulations and requirements of the various agencies of the state and federal governments . . .

And provided they prescribe and use only those medicines and drugs and appliances which have been approved by various agencies of the state and federal governments for the treatment of the conditions, and in a manner described by such agencies . . .

And provided they diagnose and treat patients only in the manner outlined by an appropriately authorized federal agency . . .

And provided they dispense professional services only with such instruments and facilities as are approved by the several agencies and committees of the local, state and federal governments . . .

And provided they render services for fees which will be determined by an appropriate agency of the federal government, and accept such fees without recourse, paid at whatever time and in whatever manner as is authorized . . .

And provided the reports and forms essential to the fiscal and statistical record-keeping functions as detailed and stipulated by an agency of the federal government are completed and maintained by the claimants . . .

And provided the practitioners agree to assume full personal and professional liability at their own risk and expense, make themselves available for service twenty-four hours a day, seven days a week (without differential pay) and to attend, at their own expense, certain designated postgraduate educational functions for at least six weeks per year, subject themselves to relicensure examinations at intervals determined by an agency of the state and/or federal government, provide for their own retirement, life-health-accident-and-hospital insurance and agree to assume all the costs of time lost on account of sickness, vacations and in meeting all the requirements of the organizations and hospital staffs in which they hold memberships and the additional requirements as describe above.

All young men and women interested in taking this exceptional opportunity to become civil servants and lead an exciting, rewarding life, apply by enrolling in the college or university of your choice this fall. MRJ



This is the political season. Candidates are filing for office. The national presidential conventions are at hand, and campaigning is building to a crescendo on both the state and national levels.

Back in the days when a physician's world was influenced primarily by his relationship with his own patients, his local colleagues and perhaps his hospital — medicine was a belovedly tranquil profession. Those days are long since past however — for today the practice of medicine is severely influenced by many other factors — certainly by federal legislation, Medicare, Medicaid, HEW, and the Federal Trade Commission and certainly by state activities — DISRS, HSA's, and the many State laws governing our practice, our hospitals and our legal liabilities. We are certainly influenced by consumer groups, and by so many persons, groups, bureaus, and governmental bodies that we no longer can "just practice good medicine." We, as physicians, are primarily concerned with our patients, but we **must** also be active in the social, environmental and political arenas now more than ever before.

Physicians are a learned group — not just in the affairs of medicine but also in the everyday affairs which influence our patients and our ability to serve them medically.

Every physician in Oklahoma and his wife, too, must become active in politics — local, state, and national, and now is the time to be strongly active in the political arena. OMPAC has been a very viable force in Oklahoma politics. We have a strong PAC — it departed from the routine course followed by most state PAC's several years ago when it became active in state political races as well as national campaigns. Our success in supporting good candidates for the State Legislature has been phenomenal and our dollars were well spent. The success in the passage of good legislation such as SB 622 on malpractice reform is only a token of that effort. We have many friends in the State Legislature and our views are respected and heard. Many important issues will be faced in the next legislature which convenes in January and now is our chance to help our friends and fight our detractors. Now is the time for each physician and his wife to become acquainted with the candidates — support the good guys — encourage couragous, intelligent men and women to run for office — let your sentiments on medical and social issues be known, and most of all to enter into politics with your thoughts, your efforts, your opinions and with your dollars. Work personally for worthwhile office seekers and by all means join OMPAC and make your financial support of good candidates have leverage for your sake — for the sake of good medicine in Oklahoma and most of all for the sake of your patients. □



OSMA JOURNAL / scientific

The Enigma Of Magnesium Deficiency In Clinical Medicine

WILLIAM O. SMITH, MD
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It has been generally accepted that magnesium deficiency may produce deleterious effects in man manifested primarily by central nervous system aberrations, neuro-muscular hyperirritability, and cardiovascular problems. When these clinical findings occur with the predisposing conditions described serum magnesium should be measured and replacement of the cation instituted.

INTRODUCTION

Doctor Helen Martin, one of the early workers in the field of magnesium metabolism, has posed the following questions:

1. "How should the practicing physician use current knowledge of magnesium metabolism? First, he should accept the fact that magnesium deficiency occurs in disease. Because of the important role of magnesium in body economy, magnesium deficiency should be treated."

and further

2. "Should the physician ascertain serum magnesium levels only if he suspects a deficit, or as routinely as serum sodium and potassium levels? Much of our knowledge of sodium and potassium in clinical medicine has come from the mass of information provided by the many serum levels obtained. For this reason, I think magnesium levels should be determined as routinely as serum sodium and potassium levels, and the results should be available as rapidly. Instruments are available for rapid, accurate magnesium determinations, and it is unfortunate that many hospitals do not have the necessary equipment."[1]

More than 40 years ago Doctor A. D. Hirschfelder of Minnesota presented evidence that alterations in magnesium levels may lead to clinical symptomatology in man.[2] This paper appeared in the JAMA but was largely ignored for the following 20 years except for a few isolated case reports in the pediatric literature. Part of the problem in slowness of the profession in recognizing the importance of this cation in human disease stemmed from the difficult, cumbersome methodology for measurement of the substance until recent years. The majority of clinical investigators now believe that a recognizable clinical syndrome may accompany magnesium deficiency and many believe that excesses of magnesium may contribute to the clinical picture of uremia.

From the Department of Medicine, University of Oklahoma College of Medicine and the Medical Service, Oklahoma City Veterans Administration Hospital.

Some two years before Doctor Hirschfelder's report veterinarians had described so-called "grass staggers" in cattle and demonstrated a relationship to magnesium deficiency.[3] Such cattle demonstrate central nervous system irritability terminating, without treatment, in fatal convulsions. At about the same time Kruse, Orent and McCollum described marked untoward effects in young rats fed magnesium deficient diets, again culminating in death due to convulsions.[4]

However, it remained for Flink and co-workers to establish magnesium deficiency as the basis of a recognizable clinical syndrome in man in 1954,[5] findings shortly thereafter confirmed in our laboratory[6] and that of Suter and Klingman[7] and subsequently in many additional laboratories.

When one mentions magnesium it immediately brings to mind airplanes, suitcases, flares and Epsom salts. It is the glamour metal of the space age; much of the material utilized in space flights has a magnesium base. Magnesium comprises about 2% of the entire earth surface.

Healing properties have been ascribed to this substance as far back as 1618 when a pool of water discovered in the English village of Epsom was found to have a purgative effect. The presumed healing effects of the magnesium containing waters attracted visitors from all of Europe and established Epsom as the outstanding health spa of its day. One unknown poet wrote as follows:

Here lies I and my three daughters,
died from drinking Cheltenham waters;
If we had stuck to Epsom salts;
we shouldn't be laying in these cold vaults.

Certainly life on our planet could not exist without chlorophyll — an essential component of which is magnesium. The photosynthetic reaction, utilizing energy from the sun, in which chlorophyll converts carbon dioxide into plant carbohydrate is, of course, necessary for animal survival from both a food and respiratory standpoint.

The human body contains 21 to 28 gms. of magnesium or about 2000 mEq. Hence it is the fourth most abundant cation in the body and the next largest intracellular cation, second only to potassium. Its primary intracellular location is indicative of its site of action in enzyme systems.

Magnesium, in addition to serving as an important element in the structure of bone, is one of the minerals essential to the metabolic processes which sustain life in man. It serves as an activator for a great many enzyme systems in the body, including enzymes concerned with the generation of energy, such as those transferring phosphate from adenosine triphosphate or to adenosine diphosphate. Oxidative phosphorylation in mitochondria is also dependent upon the presence of magnesium in the surrounding fluid.

This cation also contributes importantly to macromolecular structure, stabilizing the highly ordered organization of DNA, RNA and ribosomes. It is also involved in protein synthesis by contributing to the binding of messenger RNA to the 70S ribosome.

Magnesium has both a central and a peripheral effect on the nervous system. It is a central nervous system depressant and in sufficient amount can produce general anesthesia in man. In the periphery magnesium modulates the liberation of acetylcholine at the neuromuscular junction. This effect of magnesium is opposed by the calcium ion. Magnesium also produces peripheral vasodilatation and, when in excessive concentration in the blood, may lead to a fall in blood pressure.[8] Magnesium also slows the heart rate and depresses electrical activity of the heart.

Meat, milk and leafy green vegetables provide the dietary sources of magnesium. Approximately one-third of the magnesium ingested in the diet is absorbed and enters the body fluid system. The individual in magnesium balance therefore excretes an identical amount into the urine. The factors controlling intestinal absorption, distribution throughout body fluids, and secretion into the urine are still incompletely established. There is evidence that some of the mechanisms are the same as those for calcium, but the behavior of magnesium in crossing cell membranes is vastly different from that of calcium.

Normal serum magnesium concentration is generally regarded to be 1.6 to 2.0 milliequivalents per liter, depending upon the particular method used. Normal values using atomic absorption spectroscopy generally range from 1.6-1.9 mEq/L, although some laboratories report normal values as low as 1.3 mEq/L.[9] Older chemical methods yielded lower normal values. Since there is a wide variation between

methods and laboratories, it is essential that each laboratory establish its own normal value. Approximately one-third of the blood magnesium is bound to protein and hence is inactive physiologically. As in the case of calcium, the amount of magnesium bound to blood protein is dependent upon the concentration of protein and the pH of the blood. The concentration of magnesium in intracellular fluid varies from six milliequivalents per liter in the red blood cells to 20 milliequivalents per liter in the liver.

Etiology Of Magnesium Deficiency

Magnesium deficiency has now been reported in conjunction with the various clinical circumstances listed in Table 1.

Magnesium deficiency is seen most commonly in chronic alcoholic patients, particularly when they develop one or another of the other conditions listed in the table. At least one-half the patients with delirium tremens have a decreased serum concentration of magnesium and almost all of them have a decreased concentration of magnesium in intracellular fluid. Most alcoholics consume inadequate amounts of food and are particularly apt to avoid the foods high in magnesium content. Furthermore, ethanol itself may induce a pronounced diuresis of magnesium,[10] which in fact persists even in the face of body depletion of magnesium. Vomiting in alcoholic patients may account for additional losses of magnesium.

Excessive gastrointestinal losses of the cation account for a large number of cases of magnesium deficiency. Since gastric fluid contains only about one milliequivalent of magnesium per liter, vomiting alone would not be expected to induce magnesium deficiency unless it is prolonged and accompanied by reduced intake of the cation. However, the loss of succus entericus, which is relatively rich in magnesium, either through intestinal intubation or with diarrhea, may deplete body magnesium stores more rapidly, thus calling attention to the need to include magnesium in replacement fluid therapy in these individuals. Various forms of the malabsorption syndrome may lead to failure to absorb magnesium properly from the gastrointestinal tract.[11] As in the case of calcium, magnesium may be bound to fatty soaps within the intestinal lumen in patients with steatorrhea and inordinate amounts may be lost thereby in the stool.

TABLE 1

CAUSES OF MAGNESIUM DEPLETION

- Alcoholism
- Inadequate intake
- Excessive gastrointestinal loss
  - Prolonged, severe vomiting
  - Prolonged nasogastric suction
  - Prolonged, severe diarrhea
  - Malabsorption syndrome
- Excessive urinary loss
  - Primary aldosteronism
  - Vigorous diuretic therapy
  - Post-renal obstruction diuresis
  - Renal tubular disease
  - Hypercalcemia
  - Diabetic acidosis
  - Acute alcoholism
- Unknown mechanism
  - Hyperparathyroidism
  - Hypoparathyroidism
  - Acute pancreatitis

The proper resorption of magnesium by the renal tubule may be disturbed by the various conditions listed in Table 1. Magnesium deficiency induced by vigorous and prolonged diuretic therapy, particularly with the thiazide diuretics, probably occurs more commonly than is currently recognized.[12] Such diuretic agents have been shown to enhance urinary magnesium excretion markedly, even in normal individuals. Excessive urinary loss of magnesium during diabetic acidosis has been recognized for a number of years and many physicians now add appropriate amounts of magnesium, as well as potassium, to the replacement fluid program of these patients. Isolated cases of magnesium depletion have been reported in patients with either congenital or acquired renal tubular lesions of the de Toni-Fanconi type but such patients are rare.[13,14] A familial disorder characterized by both hypokalemia and hypomagnesemia due to excessive renal losses has been reported.[15] Recently it has also been shown that hypomagnesemia may follow the diuresis of post-renal obstruction.[16] However, it should be stressed that in the presence of uremia body magnesium levels are likely to be increased and medications containing magnesium are therefore contraindicated.

Decreased serum concentration of magnesium and negative magnesium balance have been reported in patients with hyperparathyroidism. The defect in magnesium metabolism is corrected by parathyroidectomy in some instances. The precise effect of parathyroid hormone on magnesium metabolism is not

clear, however, and some patients with hypoparathyroidism have been found to have a low serum concentration of magnesium.

Acute pancreatitis is often associated with magnesium deficiency.[17] Although many of these patients are alcoholics and are therefore already susceptible to the magnesium deficiency syndrome, patients with acute pancreatitis without alcoholism may also develop a deficiency state. Magnesium may be sequestered in the fatty soaps within the abdomen of such patients but it seems unlikely that this is the sole reason for magnesium depletion in pancreatitis. Other mechanisms remain to be clarified.

Clinical Manifestations Of Magnesium Deficiency

The hallmark of magnesium deficiency is hyperirritability of the nervous system. Clinical findings which have been described in this condition are listed in Table 2.

A striking feature of the syndrome is marked anxiety if the patient is still alert. Restlessness and agitation are noted and there is a pronounced startle reflex. Slight disorientation may also be noted and, ultimately, marked confusion. About one-half of severely depleted patients develop either auditory or visual hallucinations.

TABLE 2

CLINICAL MANIFESTATIONS OF MAGNESIUM DEPLETION

Neurologic
Marked anxiety
Disorientation
Confusion
Hallucinations
Convulsions
Hyperreflexia
Positive Babinski
Tremor

Cardiovascular
Tachycardia
Hypertension
Arrhythmias
Vasomotor changes

Other

Profuse diaphoresis
Weakness
Coma

In our experience generalized hyperreflexia is almost always present and a positive Babinski reaction may be elicited in some patients. Convulsions, usually of the grand mal type, have been reported in about one-fourth of the observed cases. Although a positive Chvostek reaction has occasionally been reported, Trousseau's sign is absent, as are spontaneous muscle contractions of true tetany. With the exception of one report in the literature, actual tetany has been described in these patients only in the presence of concurrent calcium deficiency.

An unusual tremor, which may be intermittent and resemble the so-called "hepatic flap," is frequently observed. It is an athetoid or choreiform movement of any or all extremities and is characterized by irregularity. Sometimes sudden jerks or twitches may be noted. Aimless plucking at the bedclothes is common. The general impression gained by the examiner is that of marked restlessness of the patient.

We have observed two patients with severe magnesium deficiency who showed marked auditory hyperacusis and bilateral vertical nystagmus; both findings disappeared on magnesium therapy. One of our patients complained of pain in the hands and feet as these parts assumed a bluish red appearance.

Tachycardia is often present in magnesium deficiency and transient hypertension may be observed. Clinical evidence of myocardial hyperirritability, such as premature ventricu-

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A 1944 graduate of the University of Minnesota School of Medicine, James F. Hammarsten, MD, is presently Professor and Head of the Department of Medicine at the University of Oklahoma Health Sciences Center. Among his medical affiliations are the American Federation for Clinical Research, the Association of American Physicians, the American College of Physicians, the American Lung Association and the American Thoracic Society.

lar contractions and even ventricular tachycardia, may be observed. Electrocardiographic changes have been reported in patients with magnesium deficiency. However, many patients with magnesium deficiency are also deficient in other electrolytes, notably potassium; thus, one must be careful in attributing the electrocardiographic changes to magnesium deficiency per se. However, nonspecific ST-segment depressions and low T-wave voltage, as well as frequent premature ventricular contractions and runs of ventricular tachycardia, have been observed in the electrocardiograms of magnesium-deficient patients whose other serum electrolytes were in the normal range. Abnormalities in the electroencephalogram have also been reported in several cases.

The possible role of magnesium in ischemic heart disease remains to be clarified.

Although alterations in renal function have been demonstrated in the rat with induced magnesium depletion, primarily characterized by reduction in urinary concentrating ability,[18] this effect has not been reported in man to date.

It has also been demonstrated that patients with magnesium deficiency have a defect in their ability to conserve potassium.[19-21] Therefore, when a combined deficiency state exists one must correct the magnesium depletion in order to alleviate the potassium depletion.

In summary it may be said that the clearest evidence of magnesium deficiency syndrome in man is marked hyperirritability of the central nervous system and of the neuromuscular system.

Diagnosis Of Magnesium Deficiency

The clinical picture described is obviously not restricted to magnesium deficiency. Such findings may be observed in a number of metabolic, toxic, and deficiency states. However, when these manifestations are observed in a patient with one of the predisposing conditions discussed previously, the possibility of magnesium deficiency should be considered and measurements of blood magnesium concentration should be made.

Prevention

The daily requirement of magnesium is in the order of 300 to 400 mg. Of this amount approximately one-third is absorbed from the intestine. Theoretically, then, a patient with no oral intake of magnesium can be maintained in positive magnesium balance by the parenteral administration of approximately 100 mg (8.2 mEq) of magnesium daily. This amount of magnesium is provided by 1 gm of magnesium sulfate, which can easily be added to the daily ration of intravenous fluid. This type of magnesium maintenance therapy has particular application to patients with gastrointestinal disorders and in post-operative patients requiring gastrointestinal suction.

Patients with other disorders in whom intake of food is still possible should, of course, be encouraged to eat sufficient magnesium-containing foods, principally meat, milk, and leafy green vegetables, to maintain magnesium homeostasis.

Treatment

The clinician faces the same problem in magnesium replacement therapy as he does in the replacement of potassium. Since the major portion of both of these cations occupies an intracellular position, it is not possible to calculate the total body deficit from the measurement of extracellular fluid concentrations alone. The dosage of magnesium given must therefore be determined by trial and error.

The only parenteral preparation of magnesium currently available is magnesium sulfate, which is not altogether satisfactory. The intramuscular route is generally used and 2 gm of magnesium sulfate is administered every four to six hours for the first 24 hours, following which the dosage is reduced to 1 gm every four to six hours for an additional three to five days, depending on the clinical status of the patient and the blood levels. Since intramuscular administration is painful, procaine may be added to the preparation. Magnesium sulfate may be given intravenously, in which case it should be diluted in the daily parenteral fluids to a concentration no greater than 5 gm per 1,000 milliliters of fluid. The total intravenous dosage should not exceed eight to twelve gm per 24 hours.

An overdosage of magnesium results in depression of the nervous system, which is first manifested by hyporeflexia. Calcium gluconate should be available for intravenous administration in the event of magnesium overdosage and will immediately counteract the magnesium effect. However, magnesium toxicity should not occur with the above dosage sched-

ule unless the patient has significant renal impairment. In the presence of uremia, magnesium deficiency is highly unlikely and magnesium therapy is contraindicated. In fact, hypermagnesemia is often found in patients who are uremic.

Clinical improvement is usually not observed in the patient treated for magnesium deficiency until 12 to 24 hours after magnesium therapy has been initiated. Two factors are thought to contribute to the delay in therapeutic effect: (1) a delay in dissociation of magnesium ions from the sulfate complex in vivo, a process which is necessary to a physiologic effect of the cation; and (2) a slow transport of magnesium across cell membranes, in contrast to sodium and potassium.

REFERENCES

1. Martin, H. E.: Clinical magnesium deficiency. Ann New York Acad Sci **162:**891, 1969.

2. Hirschfelder, A. D.: Clinical manifestations of high and low plasma magnesium: dangers of epsom salt purgation in nephritis. JAMA **102:**1138, 1934.

3. Sjollema, B.: Nutritional and metabolic disorders in cattle. Nutrition Abstr & Reo **1:**621, 1932.

4. Kruse, H. D., Orent, E. R., McCollum, E. V.: Studies of magnesium deficiency in animals; I. symptomatology resulting from magnesium deprivation. J Biol Chem **96:**519, 1932.

5. Flink, E. B., Stutzman, F. L., Anderson, A. R. et al: Magnesium deficiency after prolonged parenteral fluid administration and after chronic alcoholism complicated by delerium tremens. J Lab & Clin Med **43:**169, 1954.

6. Hammarsten, J. F., Smith, W. O.: Symptomatic magnesium deficiency in man. New England J Med **256:**897, 1957.

7. Suter, C., Klingman, W. O.: Neurologic manifestations of magnesium depletion states. Neurology **5:**691, 1955.

8. Kelly, H. G., Turton, M. R., Hatcher, J. D.: Renal and cardiovascular effects induced by intravenous infusion of magnesium chelate. Canad MAJ **84:**1124, 1961.

9. Seelig, M. S., Berger, A. R.: Range of normal serum magnesium values. New England J Med **290:**974, 1974.

10. Kalbfleisch, J. M., Lindeman, R. D., Ginn, H. E., Smith, W. O.: Effects of ethanol administration on urinary excretion of magnesium and other electrolytes in alcoholic and normal subjects. J Clin Invest **42:**147, 1963.

11. Heaton, F. W., Fourman, P.: Magnesium deficiency and hypocalcemia in intestinal malabsorption. Lancet **2:**50, 1965.

12. Smith, W. O., Kyriakopoulos, A. A., Hammarsten, J. F.: Magnesium depletion induced by various diuretics: J Okla MA **55:**248, 1962.

13. Booth, B. E., Johanson, A.: Hypomagnesemia due to renal tubular defect in reabsorption of magnesium. J Pediatr **85:**350, 1974.

14. Runeberg, L., Collan, Y., Jokinen, E. J.: Hypomagnesemia due to renal disease of unknown eitology. Am J Med **59:**873, 1975.

15. Gitelman, H. J., Graham, J. B., Welt, L. G.: A new familial disorder characterized by hypokalemia and hypomagnesemia. Trans Assoc Am Physicians **79:**221, 1966.

16. Preuss, H. G., Murdough, H. V. Jr.: Hypomagnesemia following the diuresis of post-renal obstruction and renal transplant. Nephron **14:**275, 1975.

17. Smith, W. O., Hammarsten, J. F., Eliel, L. P.: The clinical expression of magnesium deficiency. JAMA **174:**77, 1960.

18. Smith, W. O., Baxter, D. J., Lindner, A. et al: Effect of magnesium depletion on renal function in the rat. J Lab & Clin Med **59:**211, 1962.

19. Shils, M. E.: Experimental human magnesium depletion. Medicine **48:**61, 1969.

20. Whang, R., Morosi, H. J., Rodgers, D., Reyes, R.: The influence of sustained magnesium deficiency on muscle potassium repletion. J Lab & Clin Med **70:**895, 1967.

21. Webb, S., Schade, D. S.: Hypomagnesemia as a cause of persistent hypokalemia. JAMA **233:**23, 1975.

P.O. Box 26901, Oklahoma City, Oklahoma 73190.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

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Final classification of the less than effective indications requires further investigation.

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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The Well-Baby Visit

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In this paper several differential health providers review the many facets of well-child care and discuss its role in present day health care delivery systems.

Doctor Ordway: I approach this discussion with some diffidence. As a teacher, I am supposed to teach about well child care, yet actually I don't give much time to well-child care. My personal experience, while satisfying, is also limited, so there are with me today people who know more about well-child care than I do. We shall hear from a private practitioner of pediatrics, Doctor Sapper; from a public health practitioner of pediatrics, that is, a public health nurse, Mrs. Sammy Eagy; and also from a person who says he is characterized variously as a physician associate or pediatric assistant, Fred Olenberger, who works part-time in Doctor Shissler's office.

Perhaps it is important that we spend a session on this today, because certainly in our environment we give little more than lip-service to well-child care. On our Newborn Service, which is partially my responsibility, we devote most of our time to the small proportion of patients who have problems. We give relatively little time to the large numbers of patients who don't have problems.

Is the well-child clinic or well-child visit an anachronism today? The well-child visit grew out of the need for providing certain preventive services to children who wouldn't otherwise get them. This started out with milk clinics. The child and the mother had to come to the clinic in order to get a pure product, and at the time, this was a useful way of reducing morbidity. As the need for this sort of program disappeared, visits for immunization became important. In the 1920s, immunization with diphtheria toxin-antitoxin was added to smallpox vaccination. Since then, six additional immunizations have become available for routine use, largely in the first year of life. We have only recently abandoned recommending smallpox vaccinations in this country.

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While the well-child visit was a public health concern to begin with, this function has been progressively assumed by the pediatrician. Depending on where he practices, it represents half or more of his patient-load. In recent years, however, because well-child care has become wearisome or appears to be a waste of professional talent to some persons, the need for the physician's involvement in well-child supervision, or even the need for any well-child visit, has been questioned.

So I come back to my question: Is the well-child visit an anachronism nowadays? In the practitioner's office, well-child care is but one element in the physician's total supervision of the child in illness and health and is thus an essential ingredient in the overall care program. In most public health settings in this country, preventive medicine is practiced while curative medicine is taboo. Thus the child with a problem must be referred elsewhere for treatment, and the fragmentation of medical care so characteristic of the segment of the population most likely to attend a public well-child clinic is assured. There are two answers to the question depending on the setting: no, the well-child clinic is not an anachronism but an essential feature of the health care carried out in the private physician's practice; yes, the well-child visit *is* an anachronism as carried out in most public health settings. It should be pointed out parenthetically that in most nations, modern public health practice includes both preventive and curative medicine.

The elements of the well-child visit of concern to the physician are, and not necessarily in appropriate order; first, the prevention of certain preventable things; second, the detection of certain physical or emotional abnormalities which could be treated; third, the survey of normal growth and development and the anticipation of problems in these areas; and finally, throughout all of this, continuity. Perhaps as I mention the last we perceive one reason why we make no great pretense of giving well-child supervision in the academic setting.

Each of our panelists will comment briefly on how he sees well-child care. Afterwards we shall all gather around the table for what I hope will be lively discussion. Doctor Sapper, will you begin?

Doctor Sapper: I don't know whether the pediatrician is an anachronism at the present time. I would estimate that the average pediatrician probably does spend roughly 50% of his time on well-child supervision. What constitutes well-child care? I think it can be divided into several facets. It gives the mother a chance to discuss any problem that has come up in the rearing of the child. I think that this is very important to the mother. It allows for continued assessment of the child's nutritional status. Even in middle-class families where there are usually no economic factors, you still see a lot of things like iron deficiency without adequate nutritional supervision. And, of course, part of any visit is an assessment of the child's growth and development, "milestones" in the younger children. For older children, a few questions about the child's adjustment to school are helpful. Assessment of growth and a careful physical examination should follow.

In regard to physical examination, how many things are you going to pick up that wouldn't be picked up if you didn't have so-called well-child care? Certainly the yield is small for major things, but I think a lot of small things can be picked up and the mother reassured. Immunization status is important, and I think overall we do a pretty good job of that. A few things like tine tests and hemoglobin measurements done at the proper time are important, too.

How often do we see these children? This varies from pediatrician to pediatrician, but on the average I see most newborn infants once a month to about six months, every other month the latter part of the first year, every three months the second year, and every six months thereafter up to school age. Thereafter if we can get them in once a year we are doing pretty well. Recently we have been more successful in getting even the older children in to the office because many school systems require physical examinations. Little league football and other athletic programs have also provided quite an impetus.

Doctor Ordway: We have heard a report expressing the concerns and interests of the private practitioner of pediatrics. Mrs. Eagy, do you do the same things Doctor Sapper does? He is talking about a group of patients, all his. Do you see well-child care in terms of individual patients, do you see it more in terms of the community and its needs, or both? What sort of services are provided by the agency that you represent, the Public Health Department.

Mrs. Eagy: We work in collaboration with the private pediatrician as well as having pediatricians who work for the health department. We do not differentiate between residents of rich, middle class, or poor neighborhoods when an individual requests any of our services. Our main interest is preventive health — keeping these children well so that they can be useful people. Our work has changed considerably in the last few years. We used to go out and quarantine people to control communicable disease, then we had long lines for immunizations in schools and clinics. We are now emphasizing prevention, beginning with young children. Referrals to our agency come from hospitals, private physicians, the Oklahoma Department of Institutions, Social and Rehabilitative Services (DISRS), and the patients themselves. We prefer to see the infant as soon as the mother brings her child home from the hospital, but will accept the referral at any time. We do a total nursing-physical appraisal, looking for key points which stand out and which may need referral to other agencies.

We are also interested in nutrition. The mother may understand the preparation of the formula that the infant is sent home with, but if problems are encountered, she often changes the formula on the advice of the grandmother, aunt, or neighbor. On her return to clinic, the mother may neglect to tell the doctor or nurse that she changed the formula. We find many children are getting iron-deficient diets because the mother is not giving them supplementary iron. So we do a lot of nutrition teaching, especially emphasizing inclusion of iron-rich foods.

In teaching, we look at the young child to determine how he fits into the total family picture. We are able to evaluate the living conditions because we are in the home. Many times those children coming to our Well-Baby Clinics need to be seen in the home as well. We evaluate the emotional aspects, what impact this child has had on the family, the purpose of the pregnancy, and its apparent results. Perhaps we need to refer this mother or father for counseling. We give a Denver Developmental Screening test to each child, primarily to locate possible delays but also to teach this mother how to work with her child. What does she expect out of growth development? What does the child do now? What should he be doing? How can she work with this child? Mothers are often very insecure: the realization that the child is theirs and they are responsible can be terrifying. These parents need help in understanding that the child thinks that they are pretty great. If they have confidence themselves, then they can instill self-confidence in the child.

We look for areas for anticipatory guidance such as toilet training. There are books written on it, but a mother doesn't see that book applying to her child. It is difficult for her to recognize the factors which underlie growth and development.

We do have clinics which provide only immunizations, but our nurses are trained to look for problems as they interview for immunizations. For instance, when a child is seen who is overweight and has poor muscle tone, the mother is asked how much formula she is feeding the baby. When the problem is identified and the immediate teaching is done, the mother is invited to bring the child to the regular Child Health Conference for continued nursing supervision. Many mothers don't understand development and often don't know what questions to ask. The Health Department nurses take the time in our clinic settings to help the mother identify problems, help her plan what she will do, and make referrals as needed.

Doctor Ordway: The requirement that the pediatrician possess an ever-increasing store of knowledge, the progressive fragmentation of pediatrics and the erosion of its compass by subspecialists and and other specialists, and the capacity of non-physicians to provide good health supervision — as has just been evidenced by Mrs. Eagy — all suggest that persons other than trained pediatricians might more appropriately provide well-child care. Indeed, even non-persons may be used: questionnaires to be filled out by the parent, check-off sheets, computers. A recent article[1] showed that the computer may actually obtain more complete information than the physician, although in the study described the computer didn't reduce doctor-time. One of the more interesting recent developments has been the emergence of a new group of professionals, the physician's associates, who are capable of extending the arm of the pediatrician into areas which don't require the specialized expertise of someone who has had three years of residency

training. We have one such person in Oklahoma.

Fred Olenberger, will you tell us about your role in well-child care, how you relate to the physician, whether you are full-time in a pediatrician's office, how you relate to mothers, and what they call you — is it "Doctor?" We would like to know about your approach to well-child care.

Mr. Olenberger: You have asked a number of questions. Hopefully, I will answer a few. "Health Care Supervision, is it worth it?" In medicine there is a point beyond which you must realize that what it really boils down to is philosophies of life rather than economics. You ask the question, "Is it worth it?" Economically, it is certainly not worth seeking the one in 50,000 individuals who would be a phenylketonuria candidate. From a humanitarian point, the answer is clearly "yes, it is worth it."

As far as my role in the pediatric clinic, I screen patients and do well-baby care under the supervision of Dr. Shissler in Stillwater. There is a problem in the community as far as what mothers want to call me, and some parents insist on calling me doctor. We have tried to curtail that as much as possible, and my name tag clearly indicates that I am a Pediatric Assistant (PA). In addition, we have literature that we pass out to our mothers, but I find that I still must periodically stop them and say, "Don't call me doctor." I see the PA filling a role as a data gatherer in pediatrics as in other fields. Professionally, I would hope that I will reach a point where I can synthesize the material better than I am doing now and come up with a diagnosis before I present my patient to my employer. At this point, I have been trained to recognize the abnormal and simply call on Doctor Shissler when I see something that I think is abnormal. As far as the future of PAs, I think PAs are well entrenched and are here to stay. The question now would be what role will we play in the future? That is a controversial matter, and the medical centers around the country are jockeying for position since each feels they have the answer. Here at the University of Oklahoma, we try to train a generalist, a person who could function almost as a junior GP. Duke, on the other hand, will offer in their two-year program up to six or eight months of elective training in one special field. Colorado is putting together what will probably be the best PA programs in the country. They are taking people right out of high school into a five-year program. The first two years would be the routine 60 hours that most universities require, and then the last three years are spent in pediatrics.

Doctor Ordway: Some of the comments that have been made in relation to the value of physical examination, history, and other matters are beautifully summarized in a recent article by Yankauer.[2] Yankauer is both a pediatrician and an expert in public health. He is concerned about the most efficient utilization of health manpower, as well as about the role and satisfactions of the individual who takes care of patients. Both Mrs. Eagy and Mr. Olenberger commented on the importance of uncovering abnormalities — perhaps this is sufficient justification for the well-child visit. But I rather imagine the satisfaction for the doctor or other child care person may lie more in his relation with the parent than in his excitement over palpating a spleen. The frequency with which abnormalities are discovered is low. About three years ago, a group of practicing pediatricians in Connecticut were asked how many abnormalities they had uncovered.[3] In 6,668 visits, 130 significant abnormalities were detected, or a frequency of 1.9%. A certain number of these would have been discovered by parents sooner or later anyway, although perhaps not in time — as with Wilm's tumor — for something to have been done about them. While the 1.9% frequency compares very favorably with the one in 10,000 incidence of phenylketonuria, the low yield nonetheless raises the question as to whether certain elements could be eliminated from the routine physical examination without losing sight of important abnormalities.

Let me make a couple of observations about the quality and timing of well-child examinations. First, the importance of accurate measurements: of the few that we do, weight is usually correct, the head circumference also tends to be, but the length, or height as we incorrectly refer to it up to six years of age, frequently tends to be of relatively little use. Yet how important these observations can be when they are graphed out. Certainly, if we make these measurements, they should be accurate and be available as a running record.

Second, we have been discussing recently in Oklahoma City when the first neonatal visit should occur. Traditionally, this has been at six weeks, reflecting not the need of child or

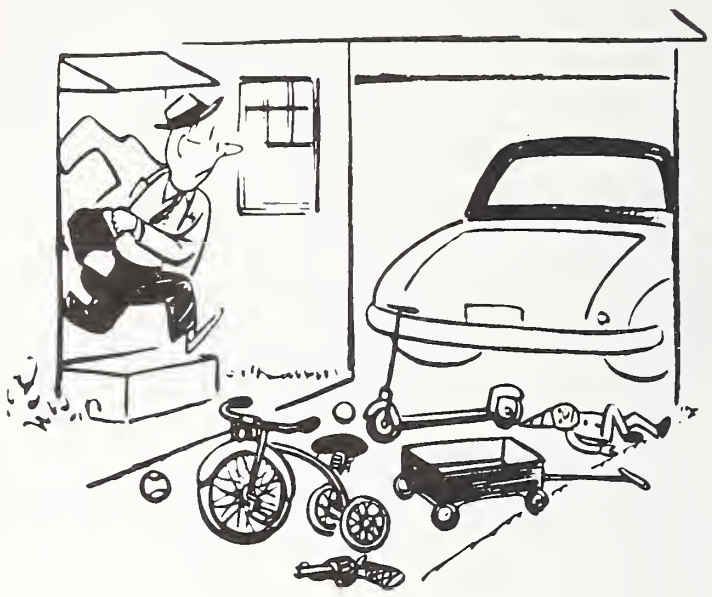
parent, but rather an irrelevant obstetrical routine. I believe that six weeks is far too late for the first visit. Others, physicians and nurses, with whom I have discussed this agree that a better time would be at a week to ten days of age so that the mother's initial concern about growth, development, behavior, and other reactions to the baby may be discussed. The only abnormality likely to be picked up at six weeks and not at ten days would be the occasional sternocleidomastoid mass that appears in a baby that has had marked intrauterine asymmetry of head position, and that might be missed anyway at six weeks since it is more likely to be present at four to five.

It was my fortune some years ago to take care of the newborn child of a colleague. The circumstances were a little melodramatic since we had just had a hurricane in New Orleans, and the streets were flooded and phones were out. The day after the baby had gone home I decided to get in touch with the family. Being perhaps more dedicated, impulsive, and devoted than I am now, I made a home visit because there was no way to telephone. I didn't have a car, so I took a bus to the nearest stop and picked my way along the high places to the home. It was a most rewarding visit. Both parents were pacing the floor. I can't remember what the problem was — it wasn't very serious — but the importance of the visit to the parents of this four or five day old baby, home only a day or so, was enormous.

One doesn't, of course, have to make the early check-up by home visit; I wouldn't have if I had had use of the telephone. But this incident underscores two things: First, a lot of acute concerns can be dissipated or at least alleviated by a knowledgeable person without too much difficulty at this early moment; and second, perhaps you have gathered what great personal satisfaction I got out of my involvement. Of course, the doctor or other attendant who is also a parent can counsel from a particularly sensitive vantage point.

So I find considerable personal rewards in well-child follow-up, particularly in the relationship with young parents of a first baby, and especially when that relationship can have begun a month or more before birth of the infant. I am not bored by well-child supervision. Perhaps I continue to be satisfied because I have the experience only about once a month.

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I Corinthians xiii, 9

Can we all sit around the table now and invite your questions?

Question: How do parents accept the PA? What is their attitude toward the examination? Do they go back and talk to Doctor Shissler afterwards, or do they talk with you, etc.?

Mr. Olenberger: In Stillwater, the parents' acceptance of me is not as good as in other places I have been. I think that is a reflection of the fact that I am the first PA in Stillwater. We have a fairly well-educated community in Stillwater, and studies in the past have shown that two distinct groups reject the PA. The very wealthy want to talk directly with the "boss." Poor people feel that they are seeing a "lesser" practitioner since they cannot meet their financial obligations. In the last few months, I have begun to see families who will now accept my opinion. Some never have, and others never will. I used to be somewhat thin-skinned about that, but now I realize that the most knowledgeable, competent, sincere physician in the world cannot keep all the patients happy all the time. Unfortunately, the public does not have a method of evaluating the quality of their medical care. It is simply a function of personalities: if they like you, you are "good," and if they don't you are "bad." I think that is how most people relate to their doctors.

Question: I would like to focus on one thing that you touched upon which relates to the de-

livery of health care to children in the United States. I think that we have a somewhat schizophrenic attitude in that I am sure most of the people here enjoy having their children followed by a pediatrician. You know that not only the routines of immunization, but also development and the like are going to be carefully screened. However, John Anderson from The University of Minnesota has calculated that providing pediatric care as outlined by Veck to all children in the United States would take every medical graduate going into pediatrics. Therefore, we find ourselves screening for PKU and providing what might be considered optimal care to some segments of the population, but not able to deliver this care to all. Certainly, I think the PA represents a unique opportunity to provide professional help in the field which has both financial training implications. You certainly could educate individuals in the healthy child (development, immunizations, and the like) and his training and interest in these areas might exceed that of the pediatrician.

Doctor Ordway: Has there been an implication in some of the foregoing comments that the full-dress pediatric review, such as is carried out by Dr. Sapper, for instance, while it is the best that can be done, is not necessarily the most useful or efficient? Yankauer has addressed himself to this effectively. When we get the help of a PA, or when we enlist the services of the public health nurse or when we ask the computer to help us out, we are simply extending the same old program, one which has never been objectively evaluated. The present recommendations of the Academy of Pediatrics are based on the considered judgment of practicing physicians who are products of both historical precedent and their current experience. Despite our asseveration that the well-child care and growth and development are the core of pediatrics, this belief has not been subjected to scrutiny that would tell us whether it is useful, whether it is making the best use of our time, or whether, as I expressed myself a moment ago, it just provides the doctor personal satisfaction at someone else's expense. I think this sort of study is necessary. Rather than spending so much time on healthy middle-class people who can afford it, maybe the same effort ought to be focused on children who are not growing well and have recurrent problems. In such cases, other, different routines may be more productive. I was referring to this earlier when I asked who might be dropped out of the physical examination? We have never changed the structure of the visit significantly. At each visit we go through the same routines. All we have done over the course of the years is reduce the number of visits. In 1967 and 1972, the Academy's Standards of Child Health Care suggested nine visits in the first year, four in the second. The next edition recommends only five visits in the first year and three in the second, but each one of these will include a complete physical examination, screening and history.

Question: Would we be able to sell this new program since apparently the majority of patients are now sold on the traditional well-baby continuum of care? Quoting from an editorial in *Pediatrics* a few years ago, a mother cannot buy a pair of shoes for her child anymore without consulting a certified pediatrician to make sure it is the correct pair of shoes. Will a mother be able to accept the fact that, at some point, all the pediatrician will do is speak with her about her child, and perhaps either the pediatrician or someone in his office will very grossly examine the child by eye? The femoral pulses which were felt at the initial visit are assuredly going to be present, the testes that were descended at the previous visit will still be descended, and there is no need to check them. Is the mother going to say, "What in the name of heaven am I doing here?" because nobody has taken the stethoscope and listened to the child's heart or lungs or looked into the child's ears or whatever it is we routinely do by ritual? I don't know that we can unsell ourselves. The complete physical examination is as oversold as anything I know. People have come to expect a complete physical examination for whatever reason.

Doctor Ordway: In this country, how much is demanded is perhaps a function of the sort of patient-society we are dealing with. But if we consider the contrast afforded by a developing country such as Chile, which is highly organized, we learn that it is not the people who are demanding the recurrent health visits; it is the doctors themselves who, perhaps looking toward the United States and seeing what is done here, provide similar services in heavily populated urban areas to rich and poor alike. Certainly it is more satisfying for most of us here to have patients come to us than it is to go out into the community or the ghetto.

Doctor Humphrey: I think that if you look at some of the trends in this country you will find there is pressure for uniformity in almost anything, whether it is medicine or medical care. All people want to be treated alike. When you start to impose programs in an effort to achieve a goal, you start getting into cost analysis. The government, using our taxes, will impose regulations on how health care is going to be delivered. To a certain extent, we have again a double problem. If pediatricians do not provide uniform care at reasonable cost, "corrections" will be made by legislation because of demands for more uniform care.

Mrs. Eagy: I disagree that you have oversold yourselves on examination. One of our requirements is that the child see a medical doctor for a complete examination every six months. In our nurse-managed clinics, we do not yet use the stethoscope or the otoscope when doing our physical appraisals. The mother chooses between using the services of the health department pediatrician or returning to her private physician for a well-child examination. We encourage this so that the private physician will get to know the child, his mother, and their interaction. Nursing supervision is not continued for those children who are not seen every six months by a health department or private physician.

All ethnic and cultural groups are represented in the population attending the Health Department Child Health Conferences in Oklahoma County.

Doctor Ordway: Doctor Ryter, would you respond to this, and include a word about something which is increasingly upon us, early periodic screening diagnosis and treatment or EPSDT?

Doctor Ryter: I wonder, just a bit facetiously, whether we are saying that the child sees the physician periodically whether he needs it or not. Granted the physicians need to see children when they are well, and more parents expect that a physician in an office will do this. I can recall several complaints to my commanding officer when I was in the Navy because we could not see a baby for a six-week check until it was nine weeks of age, and there is something sacred about the six-week check that can't wait until nine weeks.

This question of early and periodic screening diagnosis and treatment is an interesting one. It is a part of Title XIX legislation which has been in force now for a number of years. The part of it involving the screening examinations was not acted upon until several years ago. It has been implemented by various states, and the American Academy of Pediatrics has been interested. No one really knows what "early" means yet, nor has the periodicity been determined. But children who are recipients of Title XIX are eligible for this care. In fact, in this area a number of people have been given the appropriate forms which were created by the State of Oklahoma and told that they must see a physician. This leaves them in a quandary because they are are not really sure why they must see a physician. All they know is that the case worker has come out and said, "There, you must have the boxes checked appropriately by a physician." It is my understanding that the welfare department will not pay for routine well-child care in the office, but if you have one of these magic forms with whatever periodicity or earliness that has been determined, you are eligible to have this paid for as an office visit. I think the intent was good, but I suspect we are having some problems, in that the organized clinics are where many of these forms are completed and the procedure loses its value because there is no such thing as longitudinal care. A child from another county, perhaps, where this care is not available appears in the clinic for one visit only. The front side of the sheet is appropriately, or not appropriately, filled out by the mother who can't remember when or whether the child had immunizations. The back of the sheet is checked off as normal, abnormal, not done, and indications as to where remedication has been sought by the physician who will never again see this child. This is under the guise of picking up preventable handicapping conditions. And, it is a standard form which is apparently appropriate for all ages. Again we raise the question of what we should do, at what age? Need we look for a five-year-old's dislocated hip? Probably not. Should we be checking the three-month old for a visual acuity? It is extremely difficult. Certain things are appropriate at certain ages. Legislation required us to complete these forms. We feel the pinch in the outpatient department here simply because we can't do it, and we are told no one else will do it.

Doctor Ordway: I have not intended to imply that well-child care is not worthwhile. Some sort of health supervision seems to be here to stay, imposed, maybe, as Doctor Ryter, has just said, whether the doctor likes it or not. Why then should the doctor learn about well-child care if someone else, the physician's associate or the nurse, is going to take over the bulk of it? The proper answer is that the physician is not going to understand the abnormal correctly unless he understands the normal. Outside of the satisfaction the doctor may get from well child supervision, it is tremendously important that the doctor in training gets this experience. As long as physician's associates are going to rely on consultation with the physician, the doctor ought to know at least as much about the well child as the PA.

REFERENCES
TO DOCTOR ORDWAY'S COMMENTS

1. Pearlman MH, Hammond, WE, Thompson, HK Jr: An Automated Well-Baby Questionnaire, Pediatrics **51**:972, 1973.
2. Yankauer A: Child Health Supervision: Is It Worth It? Pediatrics **52**:272, 1973.
3. Anderson, FP: Evaluation of the routine physical examination of infants in the first year of life. Pediatrics **45**:950, 1970.

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Malaria and the Union Mission to the Osage Indians, 1820-1837.

HERBERT J. FORREST, MD

The greatest menace to life and health for the westward advancing Euro-Americans was the disease, malaria. Malaria was pandemic in the Mississippi river drainage area for about three hundred years. It was described by contemporary travelers according to symptoms, such as, the bilious remittent fever, intermittent or remittent fever and the ague (a shaking chill).

"From July to October the ague and bilious fever spread throughout the territory in a very unusual manner. Connected apparently with these diseases, was one of extraordinary character. It commenced by slight chills and was succeeded by a fever, attended with unremitting vomitings, accompanied with blood, and bloody foeces. Ejecting all medicine, it became next to impossible to administer relief. The paroxysms attended with excruciating pain, took place every other day, similar to the common intermittent. I was credibly informed that not less than one hundred of the Cherokees, settled contiguous to the banks of the Arkansas died this season of the bilious fever."[1]

Thomas Nuttall at Fort Smith, 1819.

"But the greatest torture without which everything else would have been a recreation, but which passes all belief, and could never be imagined in France unless it had been experienced is the mosquitos, the cruel persecution of the mosquitos. This little creature has caused more swearing since the French came to Mississippi, than had been done before that time in all the rest of the world. We are eaten, devoured; they enter our mouths, our nostrils, our ears, our faces, our hands, and bodies are covered with them; their sting penetrates the clothing, and leaves a red mark on the flesh, which swells on those persons who are not yet proof against their stings."[2]

Father DuPoisson, May 25, 1727.

Historical evidence has indicated that the malaria organism was introduced into North America, first by the Spanish, and later in heavier concentrations by imported Negro African slaves.[3] The entire Mississippi drainage area from the Appalachians to the east to the great plains to the west became intensely malarious.[4]

The malaria syndrome was labeled the intermittent fever, the ague, the bilious remittent and Autumnal fevers.[5] During the early period of southwestern settlement malaria was the greatest menace to life and health encountered by the migrating Europeans.[6] Observant travelers into the Mississippi and Arkansas river areas were appalled by the number of sick people they encountered. The seasoned natives were described as weak and emaciated with a sallow skin of a pale orange tint.[7] It was reported that the ague made up ninety percent of the fevers and certainly almost one hundred percent of the population had chronic malaria.[8,8a]

Physicians practicing in the malarious areas of the United States were slow to properly utilize the specific drug, quinine, or its precursor, Peruvian bark. This was a damaging delay

which persisted, for several reasons, until about 1850.[9] A major influence against the rational use of quinine for the treatment of malaria was the teaching of Doctor Benjamin Rush, late iterated by Doctor Daniel Drake.[10] These influential physicians advocated bleeding and purging as the primary treatment for the ague and fever. Before quinine was available the cinchona or Peruvian bark was known to be difficult to prepare and give to the fever patient. It had the disadvantage of being nauseating and purgative and was never available in sufficient quantities for the number of sick people.[11]

Quinine was extracted from cinchona (Peruvian) bark in 1820 and was first manufactured in small amounts at Philadelphia in 1823.[12]

Doctor John Sappington of Saline County, Missouri, located on the Missouri river, understood the proper treatment of the ague as early as 1819.[13] This astute physician dismissed the useless bleeding and purging treatment. He administered cinchona bark and later quinine in sufficient dosage to control malaria. Doctor Sappington's fame quickly spread through central Missouri and he greatly improved the health of travelers on the Santa Fe trade route. His book on fevers was published in 1844, too late to help the Union Mission to the south in the Indian country.[14]

The Union Mission to the Osage Indians when established near the west bank of the Grand river in 1820 was, for several years, the western point of the United States influence.[15] The site can now be reached by traveling five miles east of the village of Mazie located on Highway 69 in Mayes County, Oklahoma. In 1819 the United Foreign Missionary Society of New York sent Epaphras Chapman and Job P. Vinall to arrange for missionary stations in Missouri Territory.[16] They had intended to conduct their missionary work among the Arkansas Cherokees. After ascending the Arkansas river past the area of Little Rock they found the American Board of Commissioners for Foreign Missions from Boston had already arranged for this work so they moved on to Fort Smith. Both men became very ill with fever at Fort Smith. Reverend Vinall had the bilious remittent fever and died at Fort Smith.[17] Reverend Chapman was very sick and weak, however, he survived. He was able to contact the Osage chiefs who were at Fort Smith negotiating for the return of some of their people who had been captured by the Cherokees. Clamore's band of Osages accepted Reverend Chapman's offer to establish a mission. Reverend Chapman obtained the aid of Captain Nathaniel Pryor and together they selected the mission site. Captain Pryor showed the missionary the valley which contained the fresh water spring around which the mission would be built.[18] Reverend Chapman returned to New York and plans were completed for the missionary group to return to the Osage Country in 1820.[19]

The Union Mission family consisted of seventeen young adults and four children. They were recruited from Connecticut, New York and New Jersey. The group was made up of two ministers, a physician,* a blacksmith, farmers, mechanics and teachers. Six young women were in the group as teachers and workers.[20,20a] Reverend William S. Vaill was appointed superintendent and the four children were of his family. Mrs. Vaill wrote her brother stating that the young gentlemen of the mission family were all near or under twenty-four years of age. And, two were but twenty-one.[21]

Their journey west began in New York City, April 20th, 1820.[22] They traveled overland by stage and wagons to Philadelphia. They then crossed Pennsylvania by wagon to Pittsburgh. At Pittsburgh two large keelboats were acquired. These boats were seventy-five feet long and twelve feet wide and each carried about twenty tons. On May 24th the mission family departed from Pittsburgh to descend the Ohio river. Stops were made at various cities along the river and no traveling was done on Sundays. The ministers, Reverend Vaill and Reverend Chapman, held services in many churches along the way. Donations were received both in money and provisions. The missionaries enjoyed a pleasant interlude floating down the Ohio. A quotation indicated that they ate their meals on the roof of one of the boats and enjoyed eating while floating down the smooth surface. On Wednesday, June 21st, the boats reached the mouth of the Ohio, twenty-eight days out of Pittsburgh. Twenty days were spent actually traveling, four days observing the Sabbath, two days at Cincinnati and two days more at other stops along the way. The journey continued down the Mississippi and on Thursday, June 29th, the mouth of the White river was entered. After ascending the White river about six miles the boats reached the arm which connected to the Arkansas river. This

*Dr. Marcus Palmer of White Plains, New York.

was known as the Arkansas cut-off and saved several miles of river travel. The late start and the delays along the river route caused the missionaries to reach the lower Arkansas river on July 1st.[23]

Governor James Miller of Arkansas Territory, whose office was at Arkansas Post, received the missionaries with kindness and courtesy. He agreed to supply letters to the Indians along the way. These letters were to warn the Indians not to molest or interfere with the missionaries when they passed through their country. The missionaries had to wait until Monday for Governor Miller to complete his business. On Monday, July 3rd, the desired papers were ready. Departure of the keelboats was delayed until 5:00 p.m. because of necessary business. Two additional men were hired to help push the boats upstream. There was an urgency to move onward as the Arkansas river was at a very low stage and fear was increasing that the boats would be unable to proceed at some point.

The missionaries began to feel the evil of sickness. One of the hired men was sick as was Sister Johnson.

"The fever which prevails among us is a severe bilious remittent."[24]

The term bilious is an old medical term indicating nausea, vomiting and the regurgitation of bile. It was also used as a term to indicate a feeling of general malaise. By the next day, July 4th, another hired man was ill with fever. The brethren were helping to propel the boats as it usually required three men on each side or six men to a keelboat. A keelboat had a cleated footway all around the gunwales where the crew walked when poling the boat. The poles were about twenty feet long with an iron point at one end and a button at the other. When pushing, the pole man would place the button on a thick pad on his shoulder. He would then walk along the footway toward the stern pushing against the riverbed.[25] When the stern was reached he would lift his pole and walk forward. By keeping a steady routine of pole men pushing, the boat would be propelled upstream. Steering was by a long oar pivoted at the stern. The brethren quickly decided to try to find more men from among the settlers along the river so that six men could be utilized on each boat besides the steersmen. By July 4th, Sister Johnson was very short of breath and had a restless night and Sister Hoyt had also developed fever.[26]

On July 7th they were only able to ascend five miles upstream. Two more men were hired but one man stayed only one day because of the sickness on board. Since leaving Arkansas Post the weather had been hot and humid. Rain showers kept the boats wet. The provisions developed a foul odor. The stored flour was rapidly deteriorating. The small hot living quarters made caring for the sick most difficult. Every effort was made to clean the boats. The river water deposited an unwholesome sediment when it was used but it was the only available water.[27] About one-half of the stores were brought on deck for airing and drying.

The first death occurred at 11:00 am, Sunday, July 9th. Jacob H. Gatch, who was hired out of Pittsburgh and was described as a young man, amiable and faithful. His home was near Baltimore where his widowed mother lived. He was buried on the bank of the Arkansas about one hundred miles above the mouth .of the river. On July 12th, Sister Vaill had a violent attack of fever and Sister Lines was seized on the 15th. Sister Hoyt became disoriented with occasional lucid intervals and by July 18th was considered to be dangerously ill. Two of the brethren, Redfield and Fuller, were seized with high fevers. On Friday, July 21st, Sister Hoyt was noted to have had only one short lucid interval in three days. She died at 8:30 pm after an illness of about seventeen days. She was buried on a little hill on the river bank. A small stone was scratched with the inscription:

Dolly E. Hoyt[28]
Member of Union Mission
Age 23 1820

With the exception of Doctor Palmer and Reverend and Mrs. Chapman almost all were sick with the fever. This also included several of the hands. It seemed they could not reach Little Rock which was seventeen miles away. Four additional men were found to help make the effort but the same day, three hands left the boats because of illness. After a great struggle, Little Rock was gained on July 24th. Four of the mission family had to be carried off in litters. Several others were so weak they could scarcely walk. All were removed about one hundred rods from the river and a cabin room was rented for the most seriously ill. Little Rock was on a high bank where a cooling breeze was evident and insects were less

troublesome. A fresh water spring provided cool, fresh tasting water when for several days the only water available had been from the foul, turgid river.[29]

Sister Lines had deteriorated during the last days on the river and her fever remained high. Mental derangement became a problem with some lucid intervals. She had the same sequence of symptoms that had resulted fatally for Sister Hoyt. Sister Lines died at 1:00 am, July 26th. She was given a Christian burial service and interred in the new cemetery at Little Rock. As the days passed some of the family began to improve with their fever definitely assuming the intermittent form.[30]

"Saturday, August 5th. Most of us have paroxysms of ague and fever, some daily and others every other day. The intermittent which followed the bilious remittent is found to be very obstinate and unyielding to medicine."[31]

Another cabin was rented and the less seriously ill lived in tents. Brother and Sister Chapman, Reverend Vaill and finally Doctor Palmer all became ill with bilious fever. Brother Chapman had a prolonged period of mental confusion and at one time in early August, he was considered at the point of death. Doctor Palmer was too weak and ill most of the month to attend the sick. This compelled the family to request the services of a Little Rock physician. Later, Reverend Vaill complained about his fees which he considered too high.[32] Cooler weather finally provided the long hoped for respite. The seasonal disappearance of the mosquitos stopped the repeated reinfections and cross infections. By Sunday, November 12th every member was able to attend religious services for the first time since leaving Arkansas Post. By December 12th, 1820 it was considered that the health of the family was improved enough so it was safe to resume the journey to the Indian country. Four months and nineteen days were spent at Little Rock. The passage up the Arkansas river was laboriously slow because of low water. On January 1st the boats were stopped by shoals twenty-five miles below Fort Smith. For four weeks the river was too low to allow any forward progress. Ice and snow and extremely cold weather largely confined the missionaries to the small quarters on the boats. Finally a rise in the river enabled the boats to be pushed off the sandbars and the journey was resumed. The mission site was reached on February 18th, 1821.[33]

On March 5th several of the men made a trip to Clamore's village near the town of present day Claremore. This trip could only have been made either by walking or by riding horseback twenty-five miles north and west across the prairie from the Union Mission. However, on March 29th, 1821 Doctor Palmer was seriously ill again with a severe attack of the intermittent fever and George Requa had the same disorder.[34] During May, 1821 it was considered that the health of the brethren had been restored. On May 14th Brother Chapman went to visit the Osage village and found it had been vacated for several days. The Osages had moved westward for their summer buffalo hunt. This habit of moving out on the prairie and away from the low river areas during the summer probably reduced the rate of malaria infection for the Indians. During the early years of the Union Mission the Osage Indians seemed to have had much less of a problem with malaria than did the missionaries. In the early summer of 1821 the brethren were much encouraged by the relative absence of serious illness. By the end of July, however, Doctor Palmer and Brother Woodruff were again attacked with intermittent fever. The new hired men became ill and so the fever appeared again. The extreme summer heat made it difficult to work. The hired men who had been employed as sawyers left because of the heat and sickness.[35]

"The bilious remittent is the fever which now afflicts us."[36]

The bilious remittent fever and the intermittent fever became more severe and continued through September, 1821. In the fall of 1821 Doctor Palmer was sick again with the bilious remittent fever and he had severe pain. By September 28th, he had been lying in a state of lethargy for several days. Some Peruvian bark was obtained from Harmony Mission in Missouri. This was given to him in some wine and he began to improve. Doctor Palmer's recovery continued and by October 11th, he was able to

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A 1943 graduate of the George Washington University School of Medicine, Herbert J. Forrest, MD, has been certified by the American Board of Plastic Surgery. Doctor Forrest is a Fellow of the American College of Surgeons, and a member of the American Society of Plastic and Reconstructive Surgeons and the Midwestern and Oklahoma Societies of Plastic Surgery.

prescribe for the sick. Only two of the brethren were able to labor, and among the sisters, Miss Foster was the only one whose health was good.[37]

November, 1821 it was made known in the Union Mission Journal that Sister Cleaver had been mentally deranged since having the intermittent fever at Little Rock, July, 1820. The stress of illness and the deaths of her friends, plus all the hardships of frontier life were too much. A complete schizophrenic break occurred. The poor woman withdrew from any work or social contact. She was so ill and unpredictable that much of the time someone had to be assigned to watch her. Permission to return Sister Cleaver north to her friends was requested from the Missionary Board. A reply was received in March, 1823 instructing that she be transported by water in a safe and prudent manner.[38]

During the hot months of 1823 the chronic debilitating effects of recurring fevers were severe. Lasting weakness and poor health pursued some of the mission family for many years. Brother George Requa was so chronically weakened that it was recommended that he travel to a northern climate.[39]

New arrivals from the north were in a hazardous position. In August, 1823 Robert Bake died of bilious remittent fever. He was a laborer who had recently come down from Ohio. He was buried in the Union Mission cemetery.[40]

A quotation in September, 1823 indicated that Brother Redfield was again seized with fever and Sister Fuller remained very weak along with Sister Chapman who could not recover her health. Sister Requa was able to walk about but could not work.

On October 20th, 1823 Colonel Arbuckle at Fort Smith sent an express messenger to Union Mission for a small quantity of Peruvian bark. The mission was unable to supply this article as they had but a day or two before sent a request to the fort for the same drug.[41]

By the summer of 1824 attacks of intermittent fever were less frequent among the members of the mission family. Resistance to the disease was evidently improved. Housing was tighter and more comfortable providing some protection against the mosquitos.

As the health of the missionaries improved, the health of a few Indian families situated near the mission became worse. These were Indians who had been persuaded to settle near Union and learn agricultue. This change of residence placed them close to the mosquitos and close to the human reservoir of the malaria parasites.

The move of the Fort Smith garrison and the establishment of Fort Gibson in April, 1824, did not improve the health of the soldiers. Summer fever epidemics were severe. The services of Doctor Palmer were requested and received many times to aid the post surgeon in caring for the sick soldiers. In return, Doctor Finley of Cantonment Gibson visited and prescribed for Doctor Palmer in October, 1824. Doctor Palmer at that time was quite ill with a fever.[42]

During the remaining years of the mission to 1837 intermittent fevers were mentioned less frequently. Doctor Palmer departed in 1827 and went to Mulberry School in the Cherokee nation. Doctor George Weed of Cincinnati came later to replace Doctor Palmer. Doctor Weed stayed at Union two years and after his departure no physician was assigned to the Mission.[43]

In the summer of 1834, Reverend Jesse Lockwood and his wife of Dwight Mission made a tour of the Osage country. Dwight Mission was located about fifty miles south of Union Mission. They visited Union and found Reverend Vaill, Reverend Montgomery and Mr. Redfield with their families to be in good health. The missionaries had a happy visit together sharing experiences and discussing the future.[44]

Reverend Vaill resigned from the mission service in the fall of 1834. His resignation was prompted by the mental breakdown of his wife and it became necessary for him to remove her to the north so that she could have the care of her family. Cholera had entered the western country during the summer of 1834 and four children of Abraham Redfield died of this disease in the fall of 1834.[45]

A short time after the visit of Reverend Lockwood, Reverend and Mrs. Montgomery moved to Hopefield Mission, twenty-five miles north of Union. Cholera progressed rapidly to that region. Reverend Montgomery died August 17th, 1834. He was ill only twelve hours, and, considering his symptoms, there should be no doubt his death resulted from cholera. Mrs. Montgomery, greatly distressed from the sudden loss of her husband, returned to Union and

became very sick, not with the cholera but with the old malady, bilious remittent fever. She died September 4th, 1834.[46]

Reverend and Mrs. Lockwood had returned to Dwight Mission with no evident illness from their tour to the Osage country. However, Reverend Lockwood became ill with fever on June 30th. He had the bilious remittent fever which began as a mild illness. For several days no one was alarmed. On Tuesday, July 9th, late in the afternoon, he became agitated and confused. He had a general collapse with cold, blue extremities and profuse sweating. Death came on July 11th. Reverend Jesse Lockwood was thirty-two years of age at the time of his death. He was educated at Williams College, Princeton Seminary and Yale Divinity School. Jesse Lockwood and his wife had arrived at Dwight Mission in December 1833 and had been at his station only six months at the time of his death. His death was felt to be a great loss to the Mission movement and to the Cherokee Indians.[47]

Looking backwards from the advantage of the twentieth century it is difficult to understand the stoicism which the people of the northern United States exhibited when they ventured into the fever areas of the lower Mississippi and Arkansas rivers. Indeed, the preliminary trip of Reverend Chapman and Reverend Vinall to the Arkansas area had resulted in both of them becoming seriously ill with the fever and the death of Reverend Vinall. It required many years and several deaths of valued missionary workers before the American Board Headquarter's Staff in Boston correctly apprised the situation. On November 9th, 1838 Doctor Palmer at Fairfield Mission received a letter which indicated a change of attitude. This letter came from David Greene, secretary of the American Board of Commissioners for Foreign Missions. Mr. Greene stated that the Board did not want to send anyone from the north to the Indian Territory after March or April because of the dangerous fevers during the warm seasons.[48] Detailed reports of Jesse Lockwood's death had been sent back to the east and it would seem likely that this early and tragic death of a new missionary worker may have been the turning point in the attitude of the Missionary Board.

Abraham Redfield and Mrs. Redfield remained at the Union Mission until it was closed in 1837. The Osage Indians were to be moved to Kansas Territory and the Creek and Cherokee Indians did not wish to continue the Mission. The mission houses, the schoolhouse and the cemetery on the hill were abandoned and left to a state of silence and decay.[49]

Those who believe that most members of the human race seek to avoid pain and misery are sadly misinformed.

References

1. Nuttal, Thomas. *A Journal of Travel into the Arkansas Territory During the Year 1819.* Reprinted in R. G. Thwaites, *Early Western Travels,* Cleveland: 1906. XIII, p. 279.
2. Father Du Poisson. *A Trip up the Mississippi to Fort de Chartres.* Reprinted in M. E. Good, *Guebert Site on 18th Century Historic Kaskaskia Indian Village,* Central States Archaeological Soc. 1972.
3. Boyd, Mark F., "An Historical Sketch of the Prevalence of Malaria in North America", *Am. Journ. Tropical Medicine,* XXI, (Mar. 1941) pp 224-225.
4. Jones, Billy M., *Health-Seekers in the Southwest 1817-1900.* Norman: Univ. of Oklahoma Press, 1967. pp. 11, 12.
5. Buchan, William, *The New Domestic Medicine.* London: Thomas Kelly Publisher, 1809, p. 225.
6. Hall, Thomas B., MD, Review of Doctor John Sappington's book. *The Theory and Treatment of Fevers 1844. Missouri Historical Review,* XXXVII, No. 3, 1943.
7. Flint, J., *Letters from America.* Reprinted in R. G. Thwaites, IX, p. 288.
8. Hall, Thomas B., MD, *op cit.* p. 339.
8a. James, Edwin, *Account of an Expedition from Pittsburgh to the Rocky Mountains under Command of Maj. S. H. Long.* R. G. Thwaites, XVII, p. 86.
9. Hall, Thomas B., MD, Hall, Thomas B., III, MD, *Doctor John Sappington of Saline County, Missouri 1776-1856.* Arrow Rock, Missouri: The Friends of Arrow Rock, Inc. 1975. p. 8.
10. Hall, Thomas B., pp. 19-21.
11. Hall, Thomas B., pp. 4, 11.
12. Hall, Thomas B., p. 5.
13. Hall, Thomas B., p. 4.
14. Hall, Thomas B., p. 9
15. Foreman, Grant, *Indians and Pioneers.* New Haven: Yale University Press, 1930, p. 108.
16. Foreman, Grant, p. 94.
17. Nuttal, Thomas, *op. cit.* p. 279.
18. Graves, William W., *The First Protestant Osage Missions.* Oswego, Kansas: Carpenter Press, 1949.
19. Foreman, Grant, *op cit.* p. 94.
20. Holway, Hope, "Union Mission 1826-1836". *Chronicles of Oklahoma,* XL, 1962, p. 355.
20a. Doctor Marcus Palmer, b. 1795 of White Plains, N.Y. was the physician.
21. Asenath Vaill to her brother, Richard E. Selden, Jr. Lyme, East Haddam Post, Connecticut, May 25, 1820. Facsimiles of letters in *Union Mission File,* Oklahoma State Historical Society, Oklahoma City.
22. *Union Mission Journal,* unpublished manuscript, Oklahoma Historical Society, Oklahoma City.
23. Union Mission Journal.
24. Union Mission Journal.
25. Baldwin, Leland D., *The Keelboat Age on Western Waters,* Univ. of Pittsburgh Press, 1941, pp. 44, 45.
26. Union Mission Journal
27. Union Mission Journal.
28. Union Mission Journal.
29. Union Mission Journal.
30. Union Mission Journal.
31. Union Mission Journal.
32. Union Mission Journal.
33. Union Mission Journal.
34. Union Mission Journal.
35. Union Mission Journal.
36. Union Mission Journal.
37. Union Mission Journal.
38. Union Mission Journal.
39. Union Mission Journal.
40. Union Mission Journal.
41. Union Mission Journal.
42. Union Mission Journal.
43. Holway, Hope, *op. cit.* p. 364.
44. Letters of Cassandra Sawyer Lockwood, Annotated by Joseph B. Thoburn, *Chronicles of Oklahoma,* XXXIII, p. 224.
45. Holway, Hope, *op. cit.* p. 361.
46. Lockwood, Cassandra Sawyer, *op. cit.* p. 225.
47. Washburn, Cephas, Letter to Moses Sawyer, July 17, 1834. *Chronicles of Oklahoma,* XXXIII, pp. 232-237.
48. David Greene to Marcus Palmer, *American Board of Commissioners for Foreign Missions,* Houghton Library, Cambridge, Mass., IV, pp. 110-112.
49. Holway, Hope, *op. cit.,* p. 376.

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News From The Oklahoma State Department of Health

The Public Health Statistics Division has the responsibility of describing the health situation in the State of Oklahoma. To accomplish this, data from birth and death certificates is tabulated by the different variables including age, race, sex, occupation, etc. These statistics are then used to determine health needs in certain areas and to determine program effectiveness.

In addition to birth and death data, information on population, marriage, divorce, hospital usage, hospital costs, health personnel and many other items are gathered from different sources for dissemination to interested parties.

We strive to provide any bit of statistical health data which is available from any source to any one who has need of the data.

All information pertaining to an individual is held confidential under law and cannot be released. However, information pertaining to the general population is published on a monthly basis with a more detailed annual summary publication, both of which are available upon request.

In addition, this Division provides assistance in the design of health related studies and analysis of results of these studies. This assistance is often provided to other divisions of the Health Department but is also available to other agencies or research groups where health related data is involved.

Preparation of data for publication is another service provided by Public Health Statistics. Again this is ordinarily within the Health Department. However, assistance is provided outside the Department as time and personnel allow □

COMMUNICABLE DISEASES IN OKLAHOMA FOR MAY, 1976

DISEASE	May 1976	May 1975	April 1976	Total To Date 1976	1975
Amebiasis	2	2	—	4	6
Brucellosis	—	1	—	2	3
Chickenpox	267	213	312	1424	887
Encephalitis, Infectious	5	1	1	10	14
Gonorrhea (Use Form ODH-228)	847	940	997	5166	5009
Hepatitis, A, B, Unspecified	109	54	95	740	375
Leptospirosis	—	—	—	—	—
Malaria	—	—	—	—	1
Meningococcal Infections	1	—	2	18	8
Meningitis, Aseptic	1	4	3	9	13
Mumps	123	51	92	599	131
Rabies in Animals	23	11	17	64	58
Rheumatic Fever	2	1	1	6	6
Rocky Mountain Spotted Fever	15	21	3	19	25
Rubella	7	14	9	47	80
Rubella, Congenital Syndrome	—	—	—	—	—
Rubeola	53	72	17	266	90
Salmonellosis	17	16	9	62	68
Shigellosis	28	7	34	128	155
Syphilis, Infectious (Use Form ODH-228)	9	2	4	48	38
Tetanus	—	—	—	—	—
Tuberculosis, New Active	22	28	37	143	138
Tularemia	5	3	—	5	3
Typhoid Fever	—	1	—	—	—
Whooping Cough	—	1	—	1	12

For Consultation Call: (405) 271-4060

A Profile of Achievement: How a Handicapped Person Approaches Life

Editor's Note: The following is the first-place winning paper in Oklahoma's Ability Counts Contest. The contest is sponsored by the Governor's Committee on Employment of the Handicapped in cooperation with the Oklahoma State Medical Association and several other organizations. The award winning paper was written by Rodney L. Branch, 17, who graduated from Putnam City High School this spring. The OSMA provided his teacher, Mrs. Alva Card, with an expense-paid trip to Washington, D.C. to attend the annual meeting of the President's Committee on Employment of the Handicapped. The paper's author was sent to Washington by another sponsoring organization.



John Harris, Chairman of the Governor's Committee on Employment of the Handicapped presents a $250 OSMA check to Mrs. Alva Card. Mrs. Card is the teacher of the Committee's Ability Counts Contest winning student.

For a long time, a cottonwood tree stood tall and straight, in plain view of the passerby along the highway not far from my home. Commuters in the area passed the tree several times each day en route to work, school, or the shopping center. Since it was the tallest tree along the well-traveled route, we suburbanites easily noticed its spreading green branches and admired the tree's shade and strength. One night, during a common spring thunderstorm, lightning struck the tree that had long reigned over the highway. The cottonwood cracked near its base and lay on its side on the ground. Wet and apparently lifeless, the tree seemed to surrender itself to the elements. We residents of the area felt as though we had lost a friend. We had grown accustomed to the large landmark looming along the roadway. We were stunned at the sight of the fallen tree.

One day, several weeks after the storm, I was driving home along the highway and noticed that the broken tree was still there. I pulled over, climbed out of the car, and stared in amazement. I moved closer. A green branch was protruding out of the place where the trunk had snapped. New life was branching out of the very center of the broken base. New hope emerged from the place that had experienced the most trauma.

So it often is with a physically or mentally disabled person. If that person has stamina, perseverance, and strength, whether physical, mental, or spiritual, he can build a new life from one broken by disease or accident. He can gain new hope by his own efforts and by the understanding and aid of family, friends, prospective employers, and other community members. A broken life is a temporary tragedy, but the trauma is permanent only if one does not begin life over again.

Tom Dempsey, number 10 of the Los Angeles Rams, holds the National Football League record for the longest field goal ever kicked in a professional football game, sixty-two yards. There are many other record holders in pro-football, but Tom Dempsey's record is one of special note. Half of Tom's kicking foot has been missing since birth. He also has a withered right hand. Handicaps such as these keep thousands of Americans from even seeking employment because of the continued social and economic rejection, but, like the cottonwood tree, Tom fought back. True, Tom had been handicapped since birth, but his approach to life was the same as the tree's. He gained his fame from the very center of his personal crisis, his foot. New hope and new life emerged from the place where he had his most severe disability.

Achievement / BRANCH

Sally Jordan moves briskly down the corridor, cheerfully answering friendly "Good mornings" until she comes to the door of her private office. Her business title is proudly displayed on the door: "Chief Administrative Officer." Sally never sees her title on the door-she is blind. Her blindness never interferes with her work, however. She heads staff meetings, dictates mail, and makes important decisions at a fast pace. She, as did Tom and the cottonwood tree, emerged from personal crisis to flourish in a busy society.

Unfortunately, not all handicapped people arise from adversity with such personal triumph. Harvey lost both of his legs in a mine field in Vietnam. Sitting in a wheel chair, Harvey spends his time watching television, staring out of the window at a mobile society, playing cards, and arguing with his mother. Like the broken cottonwood when it was felled, Harvey sits damp and lifeless, seemingly surrendering to the fate that crippled him. If Harvey cannot find the courage to start again by himself, he must emulate the profiles of other disabled persons who have done so. There are many agencies to help him. The Veterans' Administration will pay for Harvey's school or on-the-job training, whichever he prefers. Many businesses have ramps and low elevator buttons for the wheel chair employees. All Harvey needs is the determination to try.

There are other people like Harvey, broken at the base, too disspirited to begin new lives. There are even a few unenlightened employers who hesitate to hire the handicapped. As a result, many people who have experienced personal crisis are dicouraged by employers who are not willing to give them a chance. Of the 1,500,000 epileptics in the United States, 85 percent of the cases can be controlled with drugs. Yet, one-fourth of all epileptic adults are out of work. Of the 435,000 partially or totally blind people, 30 percent are unemployed. Among the 236,000 totally deaf and 2,000,000 with hearing loss, unemployment is high. One in five of the 750,000 people with cerebral palsy are employable, yet only ten percent of the employable are working. The jobless rate of the people with multiple sclerosis is high, and the same is true of those with muscular dystrophy. Employers hesitate to hire the handicapped because the employer fears insurance rates will rise, that the disabled employee will be absent more frequently than other workers, and that he cannot do the work rapidly. These people are also like Harvey — they refuse to grow in understanding and knowledge. Insurance rates do not rise. The handicapped, because they have had to struggle to succeed, make excellent employees both in attendance and in work accomplished. Because of their disabilities, they do not relocate as frequently as do other workers.

John Donne, the seventeenth-century poet and minister, wrote his sermon "Meditation Seventeen" while recovering from a lengthy illness. Donne states, "Tribulation is treasure in the nature of it." He believed that from personal trials man grows in maturity and in spiritual strength. And when he does, he is a positive example to others.

With proper training and with their inner resources, the handicapped can grow out of their crises. They can, like the broken cottonwood, grow a new green branch of hope to reach out into the world and stand tall in society once again. □

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Advertising Stir Continues

Apparently the stir over professional advertising has just begun and the Federal Trade Commission will continue to take a hard, piercing look at professional societies which place ethical regulations on advertising by their members. It is also apparent that in some instances the FTC may find professional societies guilty of "restraining trade" even though they simply follow state laws.

The current investigation by the FTC of the American Medical Association's advertising policy seems to overlook the many instances in which states have passed laws prohibiting advertising by health professionals. In Oklahoma, the statutes consider such advertising "unprofessional conduct" which is justification for revoking a physician's license. The paradoxical question of which path to follow soon arises: obey the FTC and lose your license, or obey the State and be charged with restraint of trade?

Recently, a US Supreme Court decision was handed down which at first appeared to add fuel to the FTC fire. At closer inspection, however, it becomes more and more apparent that the court's decision regarding the advertising of prescription drugs relates only in the vaguest way to physician advertising.

The US Supreme Court recently struck down state laws which prohibited the advertising of prescription drugs, but, at the same time, the court carefully drew the line there and pointed out the obvious differences between pharmacy advertising and physician advertising. The justices carefully pointed out the difference between advertising "pre-packaged" merchandise and advertising a variety of services. Justice Harry Blackmun in writing the majority opinion against the state pharmacy laws said that doctors "render professional services of almost infinite variety and nature" which might justify advertising prohibitions to avoid "confusion and deception."

At the same time, however, the court ruled that advertising is protected from state laws by the First Amendment to the Constitution and that "advertising, however tasteless and excessive it sometimes may seem, is nonetheless dissemination of information."

So the uncertainty continues. Is the patient best protected by a system which allows advertising which is in good taste, or should we return to the principle of *caveat emptor* . . . let the buyer beware? It is apparent that some hard decisions will have to be made.

In response to the FTC's assault on the AMA's advertising policy, the Judicial Council of the AMA has adopted a clarifying statement about its advertising policy. The council statement points out that physicians can provide basic fee information — as long as it is not misleading — and some professional and biographical data for reputable directories of physicians.

The statement also states, however, that physicians must abide by state laws, and like Oklahoma, 33 other states also have some specific legal restrictions on advertising. Additionally, it says, many local and state medical societies have their own ethical restrictions.

The following is the complete test of the Judicial Council Statement:

Advertising

"The *Principles* do not proscribe advertising; they proscribe the solicitation of patients. Advertising means the action of making information or intention known to the public. The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours and other useful information that will enable people to make a more informed choice of physician.

"The physician may furnish this information through the accepted local media of advertising or communication which are open to all physicians on like conditions. Office signs, professional cards, dignified announcements, telephone directory listings and reputable directories are examples of acceptable media for making information available to the public.

"A physician may give biographical and other relevant data for listing in a reputable directory. A directory is not reputable if its contents are false, misleading or deceptive, or if it is promoted through fraud or misrepresentation. If the physician at his option chooses to supply fee information, the published data may include his charge for a standard office visit or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting

the amount of the fee specified. The published data may include other relevant facts about the physician, but false, misleading or deceptive statements or claims should be avoided.

"Local, state or specialty medical associations, as autonomous organizations, may have ethical restrictions upon advertising, solicitation of patients, or other professional conduct of physicians which exceed the *Principles of Medical Ethics*. Furthermore, specific legal restrictions upon advertising or solicitation of patients exists in the medical licensure laws of at least thirty-four states. Other states provide regulation through statutory authority to impose penalties for unprofessional conduct.

Solicitation

"The term 'solicitation' in the *Principles* means the attempt to obtain patients by persuasion or influence using statements or claims which (1) contain testimonials; (2) are intended or likely to create inflated or unjustified expectation of favorable results; (3) are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice; or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived.

Competition

"Some competitive practices accepted in ordinary commercial and industrial enterprises — where profit making is the primary objective — are inappropriate among physicians. Commercial enterprises, for example, are free to solicit business by paying commissions. They have no duty to lower prices to the poor. Commercial enterprises are generally free to engage in advertising "puffery," to be boldly self-laudatory in making claims of superiority, and to emphasize favorable features without disclosing unfavorable information.

"Physicians, by contrast, have an ethical duty to subordinate financial reward to social responsibility. A physician should not engage in practices for pecuniary gain which interfere with his medical judgment and skill or cause a deterioration of the quality of medical care. Ability to pay should be considered in reducing fees and excessive fees are unethical.

"Physicians should not pay commissions, rebates or give "kickbacks" for the referral of patients. Likewise, they should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public.

"Freedom of choice of physician and free competition among physicians are prerequisites of optimal medical care. The *Principles of Medical Ethics* are intended to curtail abusive practices which impinge upon these freedoms and exploit patients and the public." □

Scientists Study Cancer Treatment by Vaccine

A vaccine to combat cancer?

While final realization of this goal may yet be in the future, work on such an answer is under way today at the Oklahoma Medical Research Foundation in Oklahoma City.

The project, known as Cancer Immunotherapy, is part of the Foundation's Cancer Research Program, and is being spearheaded by G. Mark Kollmorgen, Ph.D.

"Immunotherapy relies on stimulating the body's ability to recognize and destroy abnormal cells. Normally, the body's immune system fights infections caused by bacteria and viruses. But it may also destroy cancerous cells which are abnormal," said Doctor Kollmorgen.

"Basically, we are trying to learn how properly to stimulate the body's immune system in such a way that it will selectively attack and destroy cancer cells. Before we can perfect this technique, we must understand the relationships which exist between the tumor and the immune system of the patient.

"In addition, we must be able to determine how these relationships change during the course of progressive tumor growth when metastatic, or secondary sites frequently develop. Once we understand these relationships, we hope to be able to alter the conditions which support tumor growth by inducing a strong antibiotic response against the tumor. This will be attempted by the use of vaccines made from tumor cells or from bacteria or viruses, a strategy which has proved effective in animal models."

But, the cancer researcher points out, before tumor vaccines can be successful, two vitally

important factors come into play. First, the patient or animal with cancer must be capable of responding when it is stimulated by the vaccine.

"Second, and perhaps most important, we must carefully determine the effect of a vaccine on animals in order to predict its effect in humans. Only then will we be able to select vaccines which are most likely to be effective in humans," added Doctor Kollmorgen.

He stated that studies are being conducted at the Foundation using various mouse tumors, including leukemia, lymphoma, melanoma, and breast cancer.

"Thus far, our studies have shown that, when used alone, vaccines provide little, if any, benefit in treating large tumors. But, vaccines used under the proper conditions and in combination with other treatments provide considerably more benefit.

"We have also learned that vaccines which are effective in treating one type of tumor are not necessarily effective in treating other tumors. However, several conditions which must be met for vaccines to be effective are similar for different tumors, regardless of which vaccine is being used.

"In addition, when animals are cured with vaccines, they apparently develop tumor immunity which protects them from remission or relapse," he added.

Physicians and scientists at the Foundation are presently evaluating the immune response in patients with cancer. They say if changes in the immune system are comparable to changes which have been observed in animal models, scientists should be able to identify those patients with an immune system that is functional, is not overwhelmed by rapid tumor growth, and who would likely respond to vaccines. Immunotherapy, they say, is probably most effectively used in conjunction with some other form of treatment, such as surgery, radiation therapy or chemotherapy.

"If these patients can be identified, and if a predictive relationship can be established between vaccines and their therapeutic value for different types of cancer, we hope to prolong life and increase the cure rate for cancer patients," concluded Doctor Kollmorgen. □



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AMA Brands "Unnecessary Surgery" Report Unsound

The American Medical Association has criticized a Congressional Subcommittee report on "unnecessary surgery" as unsound and has asked that the hearings on that subject be reopened.

The call for reopening the hearings was made in a letter to Representative John E. Moss (D-California) from James H. Sammons, MD, Executive Vice-President of the AMA. Republican Moss is chairman of the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce of the House of Representatives.

The AMA claimed that none of the Subcommittee's conclusions are valid because they are based on inaccurate or invalid data. In a 36-page critique, the AMA also pointed out that in several instances the Subcommittee staff either knew or had reason to suspect that the data was inaccurate. The critique accompanied the letter from Doctor Sammons.

The AMA critique pointed out that the Subcommittee staff had been informed three months before the report was issued that its figures on surgery rates for Medicaid patients were grossly inflated and that the figures were nonetheless published in the report. The AMA also charged that the method used by the Subcommittee staff to arrive at its estimates of "unnecessary surgery," the number of lives supposedly lost, and the amount of money allegedly wasted are all based on inaccurate data.

The AMA also took issue with the staff's use of second opinion studies as a measure of "unnecessary surgery."

"The medical community is virtually unanimous that second opinion studies are *not* valid measurements of surgical necessity," Doctor Sammons said in his letter to Representative Moss. Doctor Sammons recommended that the hearings be reopened in order to "resolve that issue once and for all."

The California representative was apparently unimpressed by the AMA critique and announced soon afterward that he would deal with the national medical organization only through the news media. The congressman's statement was reportedly made to the press soon after he received Doctor Sammons' letter.

Representative Moss accused the AMA of a "lack of courtesy in dealing with elected representatives of the American people," and said Doctor Sammons, "is not a responsible spokesman for American medicine."

Representative Moss added that he had not read the AMA material. □



Oklahoma Doctor Named to University Board

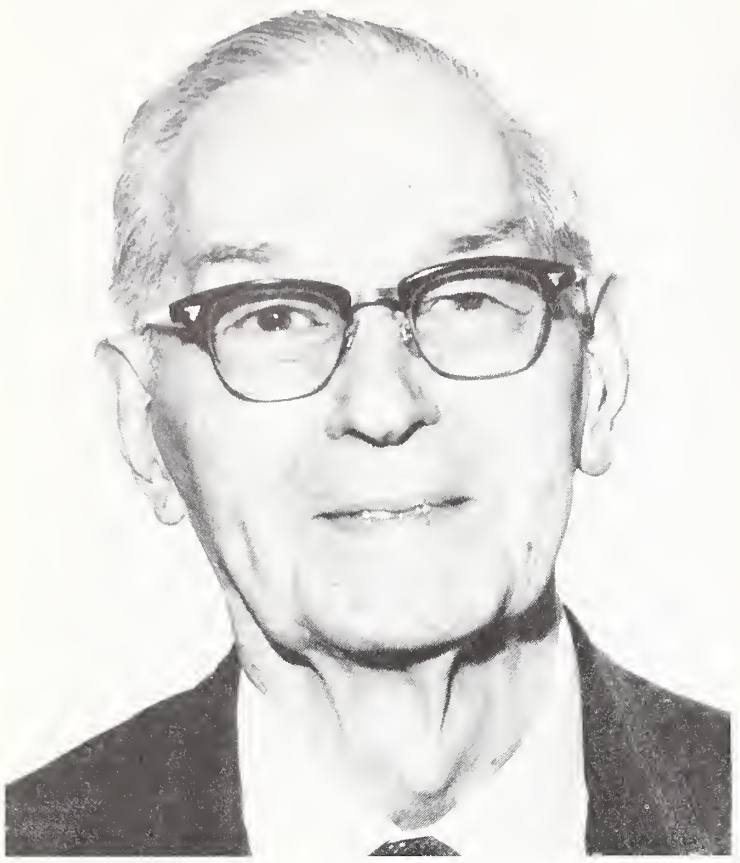
Harris D. Riley, Jr., MD, a member of the editorial board of the *Journal of the Oklahoma State Medical Association* and editor of the *Southern Medical Journal,* the monthly publication of the Southern Medical Association, has been named to the Board of Trust of Vanderbilt University.

Doctor Riley's appointment came at the Board's annual spring meeting in Nashville, Tennessee.

A resident of Oklahoma City, Doctor Riley is professor of pediatrics at the University of Oklahoma College of Medicine. He is also a consultant to the National Institute of Health. He belongs to the American Academy of Pediatrics, the Infectious Disease Society of America, and the Society for Pediatric Research.

Doctor Riley received a BS degree from Vanderbilt in 1945 and his MD degree from that school in 1948.

He was president of the Vanderbilt Alumni Association in 1974-75. □



Donovan D. Mosher, MD, Honored

At the regular June meeting of the Hughes-Seminole County Medical Society, Donovan D. Mosher, MD, received a Fifty-Year Pin from the Oklahoma State Medical Association. Doctor Mosher has been in active practice in Seminole for over a half century. He was a 1926 graduate of the University of Oklahoma College of Medicine. Presentation was made by Julian D. Wood, MD, Seminole. □

Surgical Center Bill Approved

A bill which establishes rules and requirements for centers where surgeries not requiring hospitalization are performed has been signed by Governor David Boren. The act, SB 774, provides that these centers will be licensed through the Oklahoma State Health Department which will also work out the necessary regulatory requirements.

State Senator Phil Watson, author of the bill, explained that the Ambulatory Surgical Center Act specifically states that the standards for the surgical centers must be as stringent as those required of hospitals providing the same care.

The Midwest City Senator further explained that third party payors (insurance companies) may not discriminate against these establishments in paying claims. The act further provides that these ambulatory centers may not charge more for services than a hospital would normally charge.

The provision regarding private insurance companies also applies to government agencies and therefore Medicaid and Medicare patients, said Senator Watson.

According to the Senator, the intent of this bill is to lower the cost of medical care. □

County Medical Examiners Named

The following county medical examiners have been named according to A. Jay Chapman, MD, Chief Medical Examiner: John Leland Hudson, MD, Hominy, for Osage County; Charles H. Price, MD, Okemah, for Okfuskee County; Philip C. Bryan, MD, John E. Goff, MD, Martin H. Grotheer, MD, and Terry E. Rapp, MD, all of Miami, for Ottawa County.

The local medical examiners are appointed to investigate and report such deaths occurring within their jurisdiction. It is their responsibility to determine the cause of death, order autopsies when it is in the public interest to do so, and sign the medical examiner certificate of death in such cases. □

Stillborn Child Ruling Reversed

In a precedent-breaking decision, the Oklahoma Supreme Court has ruled that parents of a stillborn child have the right to file suit in cases of wrongful death. The decision overturned the court's own previous ruling which said wrongful death suits could not be filed.

According to the court, "We find the common-law in Oklahoma as to such a cause of action has been too rigid." The majority opinion said, "It should be flexible and elastic enough to adapt to the facts of life in light of our scientific knowledge and modern society.

"Present day science, philosophy and weight of the law in this country requires us to recognize such a common-law negligence action," said the court.

In rejecting previous findings that the possible pecuniary benefit in prenatal death is too speculative to rule on, the court ordered a trial in an Oklahoma County case in which the parents of a stillborn girl filed suit against two physicians and an Oklahoma City hospital.

Eighteen other states and the District of Columbia recognize the actions brought by parents in such cases. □

Patient Loses Countersuit to Doctor

In a rare, nearly one-of-a-kind case, an Illinois patient has been found guilty of recklessly bringing a malpractice suit against her physician. The Illinois Circuit Court jury awarded the physician $8,000 in damages.

After only about 50 minutes of deliberation, the jury found the defendants in the case guilty of wanton involvement in litigation without reasonable cause. The jury also found the patient's attorneys guilty of negligence for failing to properly investigate before filing suit. Two thousand dollars in compensatory damages and $6,000 in punitive damages were awarded by the jury.

The case originally brought by Harriet Nathan charged Leonard Berlin, MD, a Chicago-area radiologist, with malpractice. Also named in the malpractice suit by Mrs. Nathan was a Chicago orthopedic surgeon. Mrs. Nathan claimed the two physicians failed to properly diagnose a fracture of her little finger which she claimed resulted in permanent disability.

Doctor Berlin and the orthopedic surgeon contended that proper x-rays were taken and that they indicated no fracture. In either case, said Doctor Berlin, the treatment would have been the same.

The countersuit filed by Doctor Berlin originally charged the defendants with barratry — inciting a lawsuit without just cause. Later, he changed the charge to recklessness. Both the suit alleging malpractice and the countersuit were to be heard at the same time by the circuit court, but soon after the trial began, Mrs. Nathan dropped her $250,000 suit. Doctor Berlin, however, chose to proceed with his case and presented expert witnesses who testified he had practiced according to the standard of medical care. Legal witnesses testified the defendant attorneys had fallen below the standard of care in bringing suit.

This case deviates from the typical countersuit in that it does not charge malicious prosecution and it was not filed after the original suit was decided. To date, few countersuits have been tried successfully.

Mrs. Nathan and her attorneys have appealed the finding. □

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"Pill Bill" Approved

A bill which restricts a minor's access to some health care has been OK'd by the Oklahoma Legislature and signed by Governor David Boren. SB 591, authored by Senator Bob Funston (D-Broken Arrow) amends a 1975 law that allowed some health care for minors without parental consent.

A major part of SB 591 prevents physicians from dispensing birth control pills and devices to minors without parental consent. It amends a new law passed last year which stated that any minor could receive non-emergency medical services for conditions which potentially threaten his health or life if delay would result from obtaining consent. SB 591 changed that section to apply only to emergency services and under the bill's definition, the prescription of medicines or devices for the prevention of pregnancy cannot be considered emergency service.

An additional change brought by SB 591 provides that a health professional *must* make a reasonable attempt to inform the spouse, parent, or legal guardian of any treatment needed or provided under the emergency treatment section.

Some question exists as to the constitutionality of the provision, however, and Representative Hannah Atkins (D-Oklahoma City) has asked for an opinion by the attorney general. Only days before the governor signed the bill, the US Supreme Court struck down a Utah law which provided that a minor whose family received welfare benefits could not obtain contraceptives from government sponsored agencies without parental consent.

Although SB 591 does not contain many of the provisions of the Utah law, the attorney general's office has indicated it will review the law and rule on its constitutionality. □

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With the November elections just around the corner and the primaries almost upon us, the role OMPAC plays is more and more important. The type of representation the medical profession will have during the next few years could very well depend upon the success or failure of OMPAC.

OMPAC is a non-partisan organization designed to help elect worthy men and women to political office. What matters to OMPAC is the candidate's personal integrity and general political philosophy, not his party affiliation. OMPAC supports Republicans, Democrats, and Independents; it supports both incumbents and challengers; it works to fill the state legislature with the best possible political candidates while its national counterpart, the American Medical Political Action Committee, works to do the same thing in Washington. To do this, however, both organizations need your help.

OMPAC's annual membership drive is now underway. If you want to participate in the election process by helping to elect worthy candidates, you will want to belong to OMPAC. Become a sustaining member of OMPAC today, and do your part to elect worthy candidates to political office.

Sustaining membership is $100 and regular membership is $20. Checks can be mailed to Oklahoma Medical Political Action Committee, P.O. Box 6645, Moore, Oklahoma 73160. If you are in a professional corporation, dues should be paid by separate **personal** check. Below are the general guidelines and philosophy of OMPAC.

OMPAC PHILOSOPHY

"OMPAC is non-partisan. Its purpose is to support and influence the successful election of candidates of either party who are men and women whose personal integrity and general political philosophy make them worthy of public trust. In pursuit of this general objective, there must be a judicious amalgamation of idealism and pragmatism. The candidate to be supported, whether incumbent or challenger, must not only possess the general qualities of character sought by OMPAC (or clearly demonstrate the potential for responsive statesmanship) but must also possess a reasonable chance to win the election. The OMPAC Board of Directors and its Executive Committee and other committees as may be formed shall act unemotionally and in a non-partisan manner in assessing the candidates against prescribed criteria and shall function in accordance with procedures described below in striving toward a principal and over-riding objective . . . to elect to public offices, both state and national, the maximum number of candidates of the highest quality attainable. This attitude may involve the idealistic support of a challenger who has a reasonable chance of defeating an unsatisfactory incumbent . . . it may involve pragmatically, the denial of support to an idealistically sound challenger when there is evidence of no chance for politcal success . . . it may involve support of an incumbent whose record is less than perfect, but who has an unassailable political base and the potential for improved relations . . . it may involve completely abstaining from an election situation where neither candidate can be supported. In any instance, OMPAC will not tender support to an incorrigible incumbent, because to do so is a greater financial and philosophical error than to support a worthy challenger who is politically without hope." □

Many Doctors Dropping Malpractice Insurance

The latest American Medical Association physician poll indicates that one out of three doctors is considering "going bare" or practicing without any malpractice insurance. One out of eight respondents in the poll or 13 per cent said he or she was currently without malpractice insurance.

According to the AMA poll, doctors either have dropped or are considering dropping insurance because of the escalating cost of premiums — in some states now upwards of $30,000 annually for physicians in high risk specialties. Oklahoma physicians in high risk specialties pay about $3,500.

Half of the surgeons (49 per cent), 44 per cent of the obstetrician-gynecologists, and 41 per cent of the psychiatrists said they are considering dropping malpractice insurance. Pediatricians (13 per cent) were least inclined to favor the idea. □

Book Reviews

COLOR ATLAS OF PEDIATRICS by Martha Dynski-Klein, 416 pp illustrated, Chicago-New York Publishers, Inc, 1975.

This is a bound collection of photographs rather than a true textbook. While the objective is commendable, the undertaking is only ambitious since the field of Pediatrics covers all disease or anomalies in all systems at different stages during development. The author has organized the material in chronologic order in spite of the fact that most of the pictures are of infants. The photographs, especially those in color, are in general of excellent quality and clearly delineate the abnormality under discussion. However, the textual material in the legends are often too brief and do not contain sufficient supporting data to warrant the assigned diagnosis. *Harris D. Riley, Jr., MD*

OPPORTUNISTIC PATHOGENS. By James E. Prier and Herman Friedman. 304 pages. University Park Press, Baltimore, 1974. $14.50

This is a collection of 15 articles from a recent symposium on opportunistic infections. In contrast to most books which publish the results of the proceedings of a symposium, this book is very readable, well organized, and well edited. The initial articles contribute a sound overview of opportunistic and nosocomial infections. There are excellent articles on biochemical methods for identification of gram negative bacilli, on the serologic diagnosis of gram negative bacilli infections and on bacteriocin typing. There are also good sections on mycotic infections, toxoplasmosis, *Pneumocystis carinii* infections and cytomegalovirus infections. The only drawback to this book is that some of the reproductions of illustrations are poor. It is recommended for persons concerned with infectious diseases. *Harris D. Riley, Jr., MD*

John D. Bauer, Philip G. Ackerman and Gelson Toro. **CLINICAL LABORATORY METHODS,** 8th Edition. The C. V. Mosby Company, 1974. 947 pages $20.00

The 8th edition of this textbook has undergone substantial revision. Descriptions of methodology in it are concise, giving the principle of each test, the techniques and reagents employed and the interpretation of the results. The book is organized into sections dealing with quality control, methods in urinalysis, semen analysis, pregnancy and placental hormones, hematology, immunohematology, clinical chemistry, microbiology, toxiocology, tissue examination and tests for cancer. The portions devoted to microbiological procedures are somewhat incomplete and superficial: For example, there is no discussion of the separation of enterococcal from non-enterococcal Group D streptococci and scant description of tissue culture techniques for viral isolation.

As a general reference, this book will be useful in medical and hospital libraries, but it should not be relied upon for information relating to clinical microbiology. *Harris D. Riley, Jr., MD*

TODD-SANFORD CLINICAL DIAGNOSIS BY LABORATORY METHODS, 15th EDITION. Edited by Israel Davidson and John B. Henry. W. B. Saunders Co., Philadelphia, 1974, 1043 pages, $28.00

This is a currently updated new edition of a standard, established text covering almost all aspects of laboratory medicine. It maintains the high standards of previous editions. The medical microbiology section which now covers about 350 pages has been significantly expanded. It now includes chapters on mycology, parasitology, virology and serology, as well as sections on mycoplasma, rickettsial and related diagnostic procedures.

This is the 66th year of publication of this text and it remains a standard reference. *Harris D. Riley, Jr., MD* □

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STYLE

Footnotes, bibliographies, and legends for illustrations should be submitted on separate sheets, double-spaced. Bibliographies should follow in order of: name of author, title or article, name of periodical with volume number, page and date of publication. These references should be alphabetized and numbered in sequence.

ILLUSTRATIONS

Illustrations, other than the author's will not be accepted for publication unless accompanied by written permission to be reproduced. Illustrations should be identified by the author's name and the figure number of the illustrations. The illustrations should be numbered in the same order as referred to in the body of the article. Used photographs, and drawings will be returned after publication if requested. *The Journal* will pay for necessary black and white illustrations within reasonable limitations. The quality of drawings, sketches, etc., must be in keeping with the quality of the magazine.

NEWS

Members of the Oklahoma State Medical Association, the constituent societies of the association, and all readers in general are invited to supply news items of general interest to the profession.

ADVERTISING

All advertising copy must be approved by the Editorial Board before acceptance for publication. General and miscellaneous advertising rates will be sent on request.

EDITING SERVICE

The Editorial Board reserves the prerogative to submit contributions to a Medical Editing Service when warranted. If such is felt necessary, the Editor will contact the author for approval, informing him that there will be a modest charge for this service.

REPRINTS

Authors will receive reprint order forms from the Transcript Press, P.O. Drawer 1058, Norman, Oklahoma 73069, prior to final publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

BACK ISSUES

Microfilm copies of back issues of *The Journal* may now be purchased from University Microfilms, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

Physicians who are new to the state or who have moved since the last *OSMA Directory* was published will be interested to know that a new physicians' directory will be published by the end of the summer. The new directory will list the address, specialty, phone number, and other pertinent information about all state-based physicians. By now, all physicians should have received a directory survey form to update, if necessary, the information published in the last directory. Physicians are urged to return this form promptly to OSMA headquarters to insure a proper listing. Clinics and others wishing to place professional listings in the new directory should contact Richard Hess, OSMA Director of Communications, about rates and procedures.

The AMA will participate in HEW's new "fraud and abuse initiative" program to crack down on the "dishonest activities of some Medicaid providers and clear the image of the overwhelming majority who are honest." C. Willard Camalier, Jr., MD, Chairman of the AMA's Council on Medical Services, is enthusiastic about HEW effort because "we too are convinced that a very small minority of Medicaid providers are actually engaged in fraudulent or abusive practices." Doctor Camalier added that the AMA's newly established Ad Hoc Committee on Medical Discipline could offer suggestions on methods of dealing with the problem.

Presidential candidate Jimmy Carter has apparently given the concept of national health insurance his full support promising to give the matter priority attention if he is elected President. The former Georgia Governor told reporters, "I'm not going to wait . . . on welfare reform, national health insurance, etc., I intend to be ready to go with that the first of the year.

"We still have a long way to go with national health care, reform of the welfare system, reform of the tax system. I don't make those commitments idly. This is something that should be done. I say that we need a national health insurance program — I mean to do it."

Officials of the Oklahoma State Health Department are gearing up to distribute over 2.5 million doses of swine flu vaccine throughout the state and they urge physicians to ready plans to administer the vaccine to the population they serve. Armond Start, MD, Director of the department's Communicable Disease Control Program, told the *OSMA News* that the vaccine, a monovalent A/swine strain and a bivalent A/swine strain and A/Victorian strain, will be available in staggered intervals beginning in late August. He said the statewide program will be carried out by districts, depending upon how much vaccine is available at a given time. The two vaccines will be distributed through local health departments to mass inoculation centers and to private physicians, said Doctor Start.

The U.S. Senate has approved by a wide margin a measure authorizing a $250 million appropriation designed to rescue the health maintenance organization program from the doldrums. The money would be spread out over five years and the legislation, which is similar to that passed by the House last year, also relaxes or removes many current federal restrictions. The most controversial feature of the measure was elimination of the open enrollment requirement for most HMOs. Senator Edward Kennedy (D-Massachusetts), a strong backer of the HMO concept, disliked this provision so strongly that he voted against the money measure in the final tally. The bill further restructures the HMO organization by requiring participating physicians to devote as little as 35 percent of their practice to HMOs and still be members of the group. Current law requires that more than 50 per cent of professional time be devoted to this type of practice. Several differences in the Senate and House versions will have to be ironed out if the measure is to be put into effect. □

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(Cover Art by William Cason)


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BATTERIES INCLUDED

A detail-man (referred to as a "pharmaceutical representative" in polite conversation) called on me today. He was courteous, well-dressed and pleasant. He didn't have an appointment, but he waited until I had finished with the last patient of the morning and, when I was sure no one was watching, I sneaked him into my office. After all, I do have to protect my reputation for the sake of my patients and my alma mater.

I recognized the name of the company he represented from the business card he had presented to my receptionist. He was young and seemed to be intelligent — actually rather decent. As he settled down in the chair I offered him, we exchanged the customary greetings and he started his pitch.

Was I familiar with his company's products? Are they effective? Do they fulfill a need? Are they safe? Did my patients accept them? Are their prices reasonable? Are they competitive? Did I understand the indications and contraindications? Did I have any problem with any of their products?

I could see right away that this young man was clever, not to mention audacious. I mean — starting right out trying to make me think he was sincerely concerned about my opinion of his products. And he sat there, pretending to be the decent guy he seemed to be — practicing competitive merchandising — while all the time he was just trying to soften me up for the further outrages he was going to commit.

After I had sort of nodded replies to his trick questions, he really warmed up. He told me that his company not only manufactured all its own products but actually discovered many of them. He said that his company stood behind every one of its products and was responsible for the safety and effectiveness of each and every pill and capsule. He told me that if I ever had any questions or complaints about his company or any of its products that I should contact him or the Medical Director and gave me a list of names and telephone numbers. Then he gave me a bunch of papers with all this stuff printed on it which described all the drugs his company makes. He called them "inserts" or something like that and suggested that I refer to them when prescribing those drugs.

Oh, I tell you, it was a most blatant effort to influence me. It was deliberate and unmitigated advertising. And it got worse.

Then this young, presumptious detail-man started the bribery for which his ilk is notorious. He asked me if I would like to have some samples of his wares to give to my patients. Can you *imagine?* To *give to my patients!* I was so startled by his question that, before I could reply, I had signed this piece of paper and he had put the bribe on my desk. Of course I wouldn't touch it — a half-dozen tablets — thinking he would surely leave without noticing my growing uneasiness. But no! The ultimate coercion preceded his departure.

He reached in his brief case and as he smiled benignly and thanked me for seeing him, he pulled out this penlight and laid it on my desk beside the box of pills. It had the name of his company actually printed on it — in big, plain letters.

Well, what could I do or say? For a fleeting moment I thought I would refuse this final insult but before I could bring myself to pick it up he had closed his brief case and was walking out the door.

After he left, I picked up the penlight and pressed the button on its top. Would you believe the light came on? It's an absolute fact: Batteries were included!

Obviously, there is no limit to the corruption of free enterprise and advertising. I'm going to take a bath. *MRJ*



"The whole mess is about as organized as a plate of spaghetti!"

That's one of the statements I've heard about the confusion surrounding the National Influenza Immunization Program. A lot of that confusion was clarified for me at a recent meeting with LeRoy Carpenter, MD, Commissioner, Oklahoma State Health Department and Armond Start, MD, Director, Communicable Disease Control Program, and our Council on Public and Mental Health. Let me share some of this with you.

Item I. A very virulent, newly mutant strain of influenza was isolated in a Fort Dix, New Jersey soldier who died three or four days after becoming symptomatic.

Item II. The virus was isolated in 13 other soldiers and over 500 had serologically positive tests. The virus mutant was now capable of being spread from person to person.

Item III. The general population of the US has no natural immunity nor cross immunity to this particular strain, referred to as A/New Jersey/76 (swine influenza virus).

Item IV. Immunological response to swine vaccine is equal to and similar to the antibody response to other flu vaccines (A Victoria & B) and is significantly evident in two to three weeks.

Item V. Virologists agree that virulent influenza epidemics occur in "waves of outbreak." The "nature of the beast" is to have minor outbreaks and then to subside, to surface in a larger outbreak and to again subside, etc., etc. This alone has led to controversy and confusion in pro and anti-immunization segments of the profession and especially in many media writings. According to medical experts, the issue is not *if* swine influenza will reach epidemic or pandemic proportions, it is only *when* it will become pandemic, 1976, '77, or '78.

The physicians of America have always been in the forefront in protecting their patients—long before there was an HEW or the Domestic Council on Health. The art of disease prevention has reached a status that gives us a very unique opportunity — one that has never existed before. By concerted action between the federal government, the medical profession and the private biological manufacturers of this country, protection can be provided to all Americans and we can perhaps head off what *could* develop into a health problem of massive proportion. This is an ideal opportunity for the medical profession to prove that our present delivery system of medical care is excellent and that the major guide we, as physicians, follow is to do what is best for our patients.

The Phase I program is to vaccinate our high risk patients, (arthritics, cardiacs, aged, dibilitated, CVR or COPD patients, etc.) as judged by the physician and to do this through our present care delivery system in Oklahoma — the physician's office and the *local* health department.

Doctor Start and Doctor Carpenter have worked out an Oklahoma Plan which is much more advanced than that in most other states. It is simpler and it has advanced informational data protections for the physicians. It also uses our own offices and existing health facilities. Judgment on who gets what vaccine (bivalent or monovalent) should be made by the physicians, as he knows best. The Oklahoma Plan will provide a steady flow of information to the physician as it becomes available so he can act with more informed judgment.

Vaccine for Phases I and II of the program will be furnished to physicians at no cost by the local health department or local health coordinator. The physician may choose to administer the vaccine at no cost to the patient (or as one group plans — ask for voluntary contributions to be given to the Oklahoma Lung Association or some other medical charity), or he may charge a nominal fee for such administration. No one is told what to charge — it is up to each physician to determine what he charges. I do trust no physician will be guilty of charging excessive fees or of denying vaccine to anyone who medically should receive it. This is an excellent opportunity to serve our patients and also to let the public in general know we care. □



OSMA JOURNAL / scientific

Progress in Treatment of Cancer of the Large Bowel

J. HORTON, MBChB
T. J. BRICKNER, MD
W. P. ILLIG, MD
J. SELF, MD
C. T. THOMPSON, MD

New approaches, often involving a multidisciplinary approach to treatment and rehabilitation, may reduce both the morbidity and mortality from this common disease.

INTRODUCTION

Over 90,000 new cases of large bowel cancer occurred in the United States during 1975. The death rate from this tumor has changed little and last year 48,000 patients died of this disease. Although there is good evidence that dietary factors play an important role in etiology[3] it seems unlikely that attempts to modify dietary habits will soon reduce the incidence of this cancer. The prognosis for patients with localized disease is good but most patients present with at least regional extension. Technics of screening for early disease, such as examining the stool for occult blood, are available but are usually used to screen individuals rather than populations. The proportion of patients presenting with localized disease has not increased in the last decade.[28] Thus, it seems reasonable to review in more detail some advances in treatment that may be capable of reducing both the mortality and the morbidity from this common disease. The role of a multimodal approach to some types and stages of colorectal cancer will be examined. It should be emphasized that improved results from a multimodal approach are most likely to occur if the combined treatment program is planned from the start.

PRE-TREATMENT EVALUATION

This involves a search to define the clinical extent of spread. Besides an appropriate history and physical examination, evidence for distant metastasis is sought by radiography of the chest, a serum chemistry profile and, if liver chemistries are abnormal or if the liver is enlarged, a radionucleide liver scan. Evidence for local and regional spread is sought by pelvic examination in women, sigmoidoscopy, barium enema, intravenous pyelography and cystoscopy if the presenting lesion is low lying and anterior. Colonoscopy may be useful to evaluate other possible sites of tumor. Carcinoembryonic antigen (CEA) is of some value for staging and as a baseline for followup.[42]

SPREAD

Death due to large bowel cancer results from the effect of distant metastases in about half

the patients and from local recurrence in the other half. Intramural extension is uncommon and rarely extends more than a few centimeters. Since most venous and lymphatic channels originate in the submucosal layers of the bowel, lesions limited to the mucosa are at little risk for dissemination. Lymphatic spread, found in nearly 50% of patients, is usually cephalad except for lesions less than eight centimeters above the anal verge. Venous drainage may be to the liver via the portal system or to other distant sites by the systemic circulation. Transperitoneal spread is unusual but occurs more commonly with colon rather than rectal cancer.

(i) Rectum (Including rectosigmoid)

The upper rectum drains to lymph nodes in the low aortic area. The lower rectum drains initially to the external iliac nodes and anal lesions can spread to inguinal nodes. Gunderson and Sosin[19] have reviewed data from reoperation on 74 patients with complete bowel wall penetration and/or positive lymph nodes found at the original operation for rectal cancer. Tumor due to rectal cancer was found in 52. Of these, 48% had local failure and/or regional lymph node metastases alone, 7.7% had distant metastasis alone and the remainder a combination of local and distant metastasis.

(ii) Colon

The ascending and descending colon as well as the splenic and hepatic flexures, like the rectum, are relatively fixed so lesions that extend through the bowel wall are likely to involve adjacent organs. This risk is less for lesions in the more mobile transverse and sigmoid colon. The right colon and between one-third and one-half of the transverse colon has lymphatic drainage to the high periaortic nodes via the superior mesenteric system. The left colon and remaining transverse colon drain via the inferior mesenteric system and can involve either the iliac or aortic lymph nodes.

Cass, Pfaff and Million have unpublished data on 105 of 280 patients with colon cancer who failed treatment. The first site of recurrence was most often (60%) just to the abdomen alone (excluding the liver). Fourteen percent had metastases both to the abdomen and to distant sites and 26% had distant metastases alone. Most of the local intra-abdominal recurrences occurred in the surgical bed or in contiguous structures. Thus, both for colon and rectal cancer, isolated regional recurrence is a major factor in treatment failure.

PATHOLOGY

The major reason for pathologic examination of large bowel resected for adenocarcinoma is to estimate prognosis. This requires both gross

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Table 1

Staging Systems Used For Anatomical Extent of Carcinoma of the Bowel

Dukes Stage*	Astler-Coller Stage[1]
A Confined to bowel wall	A Nodes negative; lesion confined to mucosa
	B_1 Nodes negative; extension of lesion through mucosa but still within bowel wall
B Through muscularis	B_2 Nodes negative; extension through the entire bowel wall
C Through serosa or regional nodes	C_1 Nodes positive; lesion limited to bowel wall
	C_2 Nodes positive; extension of lesion through the entire bowel wall

*The 5-year survival rates for patients with carcinoma of the rectum are as follows: Dukes A 79%, B 25% and C 6%.

and microscopic examination of the specimen since clinical evaluation alone at the time of operation is inaccurate in the absence of obvious distant metastasis.

Significant gross features include the location of tumor. The prognosis for rectal lesions is worse than for lesions of the intraperitoneal colon. Similarly cancers located low in the rectum do less well than those higher up.[39] Survival is decreased with increasing circumferential involvement[11] and stenotic lesions may be associated with a greater frequency of distant metastasis.[8] The prognosis for patients with obstructing tumors is approximately half that of patients with non-obstructing carcinomas.[5] Measurement of the length (unfixed) of adjacent normal bowel is necessary since there is approximately an 18% incidence of recurrence at suture lines with margins less than five centimeters from the tumor.[5]

The extent of penetration of bowel wall by tumor is evaluated upon both gross and microscopic examination. This allow classification according to Dukes criteria[10] or the Astler-Coller modification (Table 1). Pathologists differ in their interpretation and definition of these classifications so the pathology report should contain separate reference to the extent of wall penetration and involvement of serosa, fat or adjacent organs. The description of lymph nodes should include their location and enumeration of the number examined as well as the number involved. Gilchrist and David showed[14] that the five-year survival was 24% when one to five nodes are involved in comparison to 9% when six to ten nodes contained metastasis. Cellular grading of the tumor correllates with prognosis. Patients having a Broders Grade I adenocarcinoma have a 57% five-year survival. It is 42% in those with a poorly differentiated, Grade III adenocarcinoma.[5] The finding of venous or perineural invasion also implies a poor prognosis. Microscopic evidence of a moderate to heavy inflammatory infiltrate around the carcinoma is a favorable prognostic feature which may suggest a beneficial host immune response.[40,43]

An ideal pathology report demands input from both the surgeon and pathologist and should include the site and size of the primary tumor with a description of its extent through the bowel wall. The amount of bowel removed is described, together with measurement of the distance of the primary tumor to the resected margins of normal bowel. The associated tissues are described together with an anatomic as well as histologic description of nodal, fat and adjacent organ involvement. Notation is made of the cellular differentiation of the tumor, the presence or absence of vascular or perineural invasion and the extent of inflammatory reaction.

These features can be used to place patients who had had a potentially curative operation into one of two 'risk' groups. Those in the 'good risk' category have cancer limited to the bowel wall and without metastasis. 'Poor risk' patients are likely to develop metastasis and include those with involvement of regional lymph nodes, penetration of the tumor through the serosa or into surrounding fat, and histological evidence of invasion of blood vessels or lymphatics or spread to adjacent organs.

SURGERY

Surgery for colo-rectal cancer depends upon the method of presentation and its extent at the time of the diagnosis. Staged operations may be necessary when the malignant lesion presents as an obstruction or a perforation. The emergency nature of these two conditions preclude some of the diagnostic and preparatory measures that are ordinarily considered as good treatment.

(1) Obstructing cancer.

Obstructed lesions of the right side of the colon are often handled by primary resection and ileo-transverse colostomy. Preoperative

decompression and better treatment of electrolyte derangements have reduced the indications for a prior procedure. The technical problems of a right colectomy in the face of acute obstruction are usually not great and a good cancer operation can be performed. An occasional patient will be seen with a highly competent ileocecal valve. This, in effect, presents as a "closed loop" type of obstruction and may need a decompressive cecostomy by needle or tube in order to facilitate handling of the intestine.

Primary resection and anastomosis of a completely obstructed distal colon is risky because of infection, edema and disparity between the size of the bowel segments to be anastomosed. Creation of a proximal colostomy, remote from the obstructing lesion, is indicated. Accurate preoperative diagnosis of the location of the obstruction aids in minimizing the surgery and planning for future operations, even in the case of acute obstructing lesions. Several points on colostomy should be emphasized.

a. The colostomy site should avoid the costal margin and other bony protuberances, folds or scars and the beltline.

b. It should be visible to the patient.

c. The skin and fascial openings should be large enough to allow the bowel to exit, but small enough to not give a paracolic hernia.

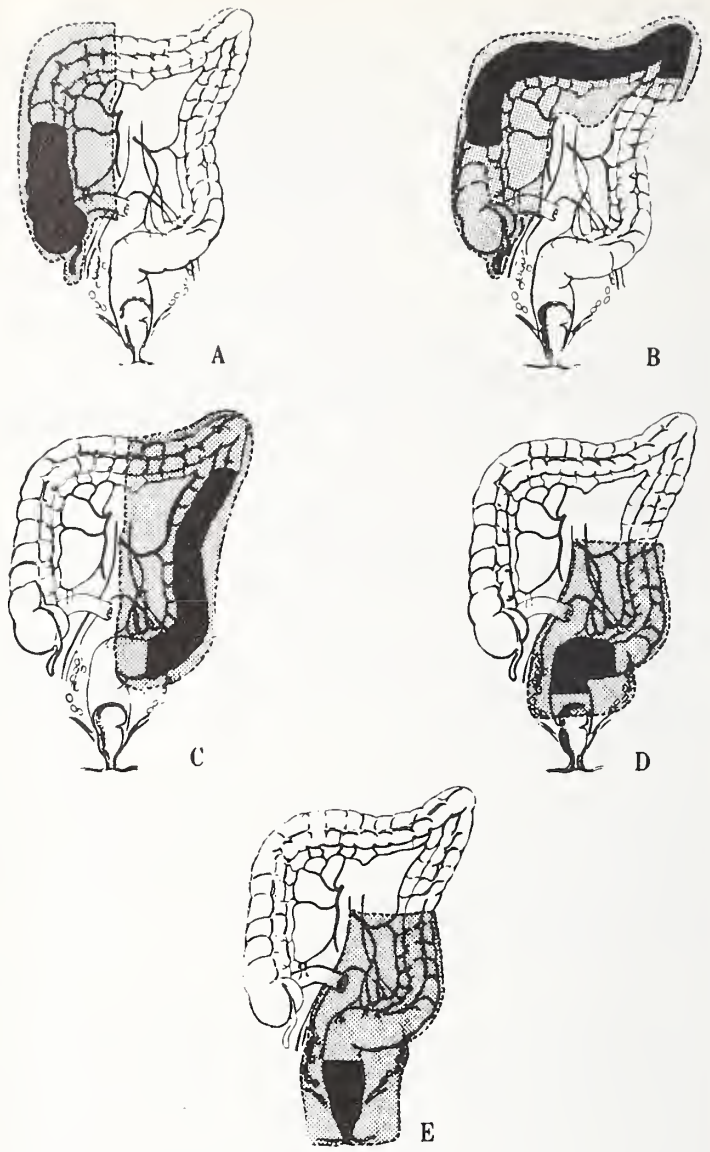
d. Immediate opening of the colostomy and evacuation of bowel contents may be accomplished so long as the wound is protected.

e. Early suture of the mucosa to the skin, *ie* "maturation," can be accomplished at the time of surgery.

Once the obstruction has been relieved, the procedures to determine the extent of the cancer and the planned treatment are completed.

2. Perforated cancer.

Perforated cancer traditionally has been associated with a poor prognosis. More recent reports have suggested that an aggressive treatment approach might improve prognosis.[9] Because of the accompanying generalized peritonitis, sepsis is treated with adequate lavage and debridement of the peritoneal cavity at the time of the original surgery. Excision of the colon containing the perforated carcinoma is carried out with attention paid to technic to prevent further leakage and for the



The usual limits of intestinal and mesenteric resection (gray area) are indicated for adenocarcinomas occurring in the black area in each of the diagrams. A. cecum and ascending colon, B. hepatic to splenic flexure, C. left colon, D. sigmoid and rectosigmoid colon and E. rectum. (modified from Enker.)[12]

resection of enough mesentery to give a good "cancer operation." Both the proximal and distal ends of the bowel are usually exteriorized for later anastomosis.

3. Elective Surgery

Curative resection means *en bloc* resection of the tumor and its lymphatic drainage. Good technique[41] includes gentle handling of the tissue, ligation and division of the vessels with their associated lymphatic channels as early as possible in the operation, and minimizing disturbance of the tumor. Electrocoagulation or cryosurgery for small lesions of the rectum should be considered in patients who are poor surgical risks. These techniques can also palliate fungating and obstructing rectal tumors. Satisfactory limits of resection of malignancies in the various locations in the colon and rec-

tum are summarized in Figure 1.[29]

Careful preoperative evaluation of the level of the tumor is necessary for distal lesions. Low anterior resection is performed for lesions of the upper rectum and rectosigmoid. It is important, as in abdominal perineal resection, to remove the hypogastric lymph nodes, as well as the preaortic nodes following division of the inferior mesenteric vessels. An abdomino-perineal resection is indicated for lesions within a few centimeters of the anal verge. Anal sphincter-saving procedures are possible if more than three to five centimeters of bowel adjacent to the tumor can be excised. Local resection of villous adenomata is sometimes best performed by the posterior approach of Kraske.[27, 29]

4. Palliation

Surgical resection of primary large bowel cancer is often indicated even in the face of known distant metastasis to reduce symptomatology from obstruction, perforation, bleeding, oozing and pain. Residual tumor can be marked with clips to facilitate adjunctive therapy. Tumor excision and primary anastomosis can be performed in most colon lesions. Inoperable lesions of the rectum present a greater problem and resection is not indicated in very poor risk patients. These patients may be palliated by fulguration or cryosurgery. Pain-relieving procedures are sometimes indicated and infusion technics may be utilized to provide local chemotherapy to the liver or, less often, to an extensive primary tumor. Resection of apparently isolated metastases from the abdominal wall, liver, lung or brain is occasionally indicated. This is of clinical value only if the lesion indeed is isolated and there is clinical evidence (for example a one year or longer 'tumor-free-interval' from the time of diagnosis to the time of the metastasis) that the tumor is slowly growing.

5. Second Look

There is little indication for a policy of re-operation of asymptomatic patients who have had a potentially curative resection. Although isolated local or regional recurrence is sometimes found, this can rarely be completely excised with resulting cure. Some authors have, however, suggested that the finding of a CEA rising from previously normal levels might be an indication for 'second look' operations.[42]

Contrary to general opinion, adenocarcinoma of the large bowel is sensitive to clinically tolerated doses of radiation. This modality has a role in the management of symptomatic persistent or metastic disease, particularly in the pelvis or perineum. Rider[38] has shown that radical external radiation has resulted in a 25% five-year survival, free of disease, in a group of patients with mostly inoperable and advanced rectal cancer. Contact radiation, as developed by Papillon,[35] is also used in some centers in this country for cure of small, accessible rectal carcinomas.

Since large bowel cancer is prone to develop regional recurrence and radiation is most effective when there is a minimal tumor burden, it seems logical to examine the use of radiation in the peri-operative period. Most reported studies have examined the role of pre-operative radiation in rectal cancer. The early experience from Memorial Hospital, NYC[37] suggested that low dose (1500-2000 rads using 250 KV radiation) pre-operative therapy improved the survival of patients with involved lymph nodes (27% vs. 23% at five years and 27% vs. 10% at ten years respectively). A subsequent prospectively randomized study of 700 patients from the same institution, however, failed to confirm these data.[36] The Veterans Administration Surgical Adjuvant Group study used 2000 rads given in 10 increments of 200 rads over a two-week interval to the midplane of the pelvis through opposing antero-posterior portals. Lymph nodes were involved in only 27% of the specimens resected in the patients who received pre-operative therapy as compared with 40% in the control group. The five-year survival of the patients undergoing combined abdomino-perineal resection was 46% for the control group and 30% for the controls.[21] Several studies are now being performed to examine whether higher doses of radiation, given pre-operatively, can improve these figures. Preliminary results from one such study[26] indicate that 11 of 16 patients randomized to surgical resection alone had tumor in the regional lymph nodes whereas only 3 of 13 treated with 4400-4600 rads from a 6 MEV linear accelerator over a period of 4½ weeks had positive nodes. Survival data from this study are not yet available.

A policy of giving radiation postoperatively has several potential advantages. First, accurate staging together with marking both the

known and potential regional extent of disease can be performed. Second, radiation for colon as well as rectal cancer can be planned and third, patients with Dukes A lesions or those with unsuspected metastasis to the liver can be spared unnecessary radiation. The major drawback to such therapy is the potential increased toxicity that is possible if small bowel in the radiation field becomes adherent and fixed post-operatively. Although this approach is still considered experimental, early reports[18] suggest that treatment is well tolerated and further exploration of this approach is anticipated.

SYSTEMIC THERAPY

1. Advanced Disease

5-fluorouracil (5-FU) has been used for large bowel cancer for almost 20 years. Many methods have been proposed for its use. Recent data[20] suggest that a five-day course of intravenous bolus injections is probably the best method of administration. Nevertheless, the actual incidence of objective response in patients who have measurable parameters of disease is still only approximately 20%. Many other agents have received trial in patients with metastic cancer.[24] Drugs with demonstrated activity include mitomycin C[30] and various nitrosoureas.[32] The nitrosoureas are lipid-soluble agents that have a spectrum of activity somewhat similar to that of alkylating agents. Methyl CCNU, an orally administered (but still experimental) agent may be the most effective nitrosourea for large bowel cancer with a 17.5% incidence of objective response in 40 patients treated.

Many combinations have been tried in colon and rectal cancer. The vast majority have not given any more antitumor effects than 5 FU.[24] An exception to this generalization is a report of 9/15 responses to a combination of mitomycin C, 5-Fu and cytosine arabinoside.[34] This was not confirmed by investigators in this country.[7] More recently, it has been shown that various combinations that include nitrosoureas with 5-FU are more effective than 5-FU alone. These include 5-FU + methyl CCNU (3540%),[20] 5-FU + methyl CCNU + vincristine (43%),[33] and 5-FU + bis-chloroethylnitrosourea + diaminotriazenomidazole carboxamide + vincristine (42%).[13]

2. Surgical Adjuvant

Surgical adjuvant chemotherapy for large bowel cancer is an attractive concept and is widely practiced. 5-FU is the most commonly used agent. There is, however, a paucity of data to support this approach using this agent alone. Those studies of such adjuvant therapy that have included a control, or no treatment arm have tended to show no benefit in terms of survival for the treated group. The Veterans Administration Surgical Adjuvant Group, for example, tested intravenous courses of 5-FU in 482 patients.[22] The three-year survival for those thought to have had a curative resection was 63.7% in the treated and 60% in the control group. The two-year survival for those who were thought to have had only a pallative resection was 21.4% for the treated and 21.8% for the control group. The results of a randomized trial of 5-FU given first intraluminally at the time of the operation and then systemically indicate no overall benefit for the treated group with the exception of a small sub-group of patients with serosal penetration.[17] A recent study of the Central Oncology Group[16] reports that only those patients in the treated group who developed toxicity to 5-FU during treatment lived longer than those who did not. Since the other single agents available for treatment of large bowel cancer are less effective than 5-FU, it is unlikely that surgical adjuvant therapy with any of the currently available single agents will give major benefit.

In most instances (for example Wilms' tumor) where chemotherapy has been demonstrated to be effective as an adjuvant to surgery, the chemotherapy has been capable of causing objective responses in about 50% of patients with advanced and measurable disease. Thus, it seems likely that the newer combination treatments, that include 5-FU and the nitrosoureas may be capable of lengthening disease-free intervals and prolonging survival. These combinations, however, give appreciable toxicity which includes nausea and vomiting. Hematological toxicity is less predictable than that associated with 5-FU alone and thrombocytopenia with bleeding becomes a threat, especially in later courses.

Since retention of delayed hypersensitivity reactions is associated with longer survival in patients with many solid tumors including breast cancer,[6] it is attractive to postulate that stimulation of specific or non-specific host

anti-tumor immunologic reactions might be beneficial in large bowel cancer. Immunological factors do exist in colon carcinoma. The carcinoembryonic antigen was described by Gold[15] but this does not cause delayed cutaneous hypersensitivity reactions or lymphoblastogenesis in patients with large bowel cancer. Other extractable antigens, however, may be capable of producing this effect.[23]

Non-specific immunotherapy that is currently being tested as an adjuvant to other treatments for large bowel cancer includes Bacillus Calmette-Guerin (BCG),[31] its methanol extracted residue (MER) and Corynebacterium parvum. These treatments all have significant side effects that include fever and systemic infection. They are as yet of unproven value and should be used only under controlled conditions on an experimental basis.

REHABILITATION

While every patient with cancer needs some degree of rehabilitation, those who have an enterostomy have special physical and emotional needs that are not always met by physicians and nurses. Enterostomal therapists, usually registered nurses with special training, can fulfill many of these needs. Pre-operative counseling is particularly valuable as a preparation for the imminent changes in body image and function. Postoperatively, the therapists also give practical help and advice on the best ways to collect the elimination, protect the skin and control odor.

INTEGRATED APPROACH

From the preceding discusson, it is obvious that a large proportion of patients presenting with large bowel cancer can potentially derive benefit from a planned multimodality approach. The sequence of treatment is not necessarily fixed in the order surgery→radiation→systemic therapy. Some rectal tumors, for example should receive preoperative radiation. If chemotherapy is also a possibility, modifications of the radiation approach may be necessary. These decisions relating to pre-operative treatment can obviously be carried out only if the appropriate specialist has seen the patient before operation.

Fortunately, the pre-operative evaluation by the surgeon can usually provide a good estimation of what the eventual results of the subsequently developed detailed anatomic-pathologic staging and grading will be. Thus, it is possible for physicians to define acceptable approaches that should be followed in the majority of instances. These can be summarized, posted and circulated and used as criteria for audit procedures. An additional advantage of such a system is that it defines the treatment group areas in which they may wish to perform clinical investigative studies. A suggested 'pre treatment' schema for patients without obvious distant metastases is indicated in Table 2.

Table 2

Guidelines For Integrated Management of Carcinoma of The Large Bowel Based on Preoperative Factors

Site	Size	Special Studies	Consultation Indicated
Rectum and recto-sigmoid colon	Small	CEA*	Radiation oncology, enterostomal therapy
	Large	CEA	Radiation oncology, medical oncology, enterostomal therapy
Colon	Small	CEA	None
	Large	CEA	Radiation oncology

*May be of some aid in staging and as a baseline for followup studies. Ultimate value of this test not yet fully established.

Postoperatively, patients can be more exactly divided into good-risk and poor-risk categories based on staging and pathology. A suggested schema for approach is indicated in Table 3.

FOLLOW-UP

Treated patients need to be followed both because of the risk of development of metastasis as well as the risk of developing new cancers in the large bowel or, in females, the breast.[25]

Table 3

Guidelines For Integrated Management of Large Bowel Cancer Based on Operative and Pathology Findings

Site	Risk Category	Consultation Indicated
Rectum and recto-sigmoid colon	Good	Enterostomal therapy
	Poor	Radiation and medical oncology, enterostomal therapy
Colon	Good	None
	Poor	Radiation and medical oncology

Those patients who have colostomies usually benefit from membership in 'ostomy associations.' Follow-up should be at shorter intervals in patients who are at high risk of developing recurrences than those who have more favorable cancers. It is possible to design Tumor Registry activity to send out 'reminder' letters to physicians at intervals that are deemed appropriate locally in order to stimulate continued follow-up. The following table summarizes some guidelines that may be considered for use:

Table 4

Guidelines for Follow-up of Cancer of the Intestinal Tract
(Modified from Bradley and Barrett[4])

	Dates Suggested for Follow-up / Suggested Procedures	3 months	6 months	9 months	1 year	18 months	2 years	30 months	3 years	Annually for Life
HISTORY	Appetite	x	x	x		x		x		
	Frequency, Color and size of stools	x	x	x		x		x		
	Abdominal pain	x	x	x		x		x		
	Weight gain or loss	x	x	x		x		x		
PHYSICAL	Complete				x		x		x	x
	Liver	x	x	x		x		x		
	Abdomen	x	x	x		x		x		
	Rectal and Prostate or Stoma (1)	x	x	x		x		x		
	Supraclavicular lymph nodes	x	x	x		x		x		
	Female Breasts	x	x	x		x		x		
	Pelvic & Pap	x			x		x		x	x
	Sigmoidoscopy		x		x	x	x		x	x
	Complete				x		x		x	x
ANCILLARY	CBC	x	x	x	x	x	x	x	x	x
	Stool for blood		x		x	x	x	x	x	x
	Chest x-ray				x		x		x	x
	Barium enema (2)				x		x		x	or every 2 years
	CEA		?		?		?		?	?

Notes: (1) Abdominoperineal resection precludes palpation of prostate and rectum.

(2) CEA is of uncertain value. If positive before and negative after surgery, a return to positive may suggest further investigation for recurrence.

SUMMARY

Recent developments in the management of patients with large bowel cancer include better definition of patients at high risk of developing recurrence or metastasis. These patients should benefit from a multi-modal approach to treatment. Radiation therapy is probably capable of reducing the incidence of regional metastatic spread when used in conjunction with surgery. Combination chemotherapy is providing better remission rates than 5-FU alone in patients with advanced cancer. These more effective combinations may, in contrast to 5-FU alone, be capable of prolonging the disease-free interval when used as an adjunct to local and regional treatment. In order to bring benefit to the maximum number of patients, decisions on the optimum treatment approach should best be made by a functional team of specialists in surgery, pathology, radiation, chemotherapy and rehabilitation.

BIBLIOGRAPHY

1. Astler, V. B. and Coller, F. A.: The prognostic significance of direct extension of carcinoma of the colon and rectum. Ann. Surg., **139:**846-851, 1954.

2. Baker, L. H., Matter, R., Talley, R. and Vaitkevicious, V.: 5FU vs. 5FU and MeCCNU in gastrointestinal cancer. Proc. Am. Soc. Clin. Oncol., **16:**229, 1975.

3. Berg, J. W., Howell, M. A. and Silverman, S. J.: Dietary hypothesis and diet-related research in the etiology of colon cancer. Health Serv. Rep., **88:**915-924, 1973.

4. Bradley, E. T. and Barrett, H. S. (Eds) Followup of Cancer. A Handbook for Physicians, Connecticut State Medical Society, American Cancer Society, Connecticut Division Inc. and Connecticut State Department of Health, p. 11, 1972.

5. Copeland, E. M., Miller, L. D. and Jones, R. S.: Prognostic factors in carcinoma of the colon and rectum, Am. J. Surgery, **116:**875, 1968.

6. Cunningham, T. J., Horton, J., Sponzo, R., Taylor, S., Rosenbaum, C. and Knight, E.: The correlation of DNCB skin testing with the clinical course in patients with recurrent breast cancer, Cancer, (in press) 1976.

7. DeJager, R., Magill, G. B., Golberg, R. B. and Krakoff, K. H., Mitomycin C, 5 fluorouracil and cytosine arabinoside (MFC) in gastrointestinal cancer, Proc. Am Assoc. Cancer Research, p. 178, 1974.

8. Dionne, L.: The pattern of blood-born metastasis from carcinoma of the rectum, Cancer, **18:**775, 1965.

9. Donaldson, G. A. and Welch, J. P.: Management of cancer of the colon, Surg Clin North America, **54:**713-731, 1974.

10. Dukes, C. E.: Classification of cancer of rectum, J. Path. Bact., **35:**323-332, 1932.

11. Dunning, E. J., Jones, T. E. and Hazard, J. B.: Carcinoma of the Rectum: Study of factors influencing survival following combined abdominoperineal resection of the rectum, Ann Surg **133:**166, 1951.

12. Enker, W. E.: Carcinoma of the colon and rectum, Surgical Clinics of North America, **56:**175-187, 1976.

13. Falkson, G., VanEden, E. B. and Falkson, H. C.: Fluorouracil, imidazole carboxamide dimethyl triazeno, vincristine and bischloroethyl nitrosourea in colon cancer, Cancer, **33:**1207-1209, 1974.

14. Gilchrist, R. J. and David, D. C.: A consideration of pathologic factors influencing five year survival and radical resection of the large bowel and rectum for carcinoma, Ann Surg., **126:**421, 1947.

15. Gold, P. and Freedman, S. O.: Demonstration of tumor-specific antigens in human colonic carcinomata by immunological tolerance and absorption techniques, J. Exp. Med., **121:**439-462, 1965.

16. Grage, T. et al: Adjuvant therapy with 5FU after surgical resection of colorectal cancer, Proc. Am. Soc. Clin. Oncol., **16:**258, 1975.

17. Grossi, C. E., Wolff, W. I., Nealon, T. F., Pasternack, B., Ginzburg, L. and Rousselot, L. M.: Topical 5FU chemotherapy adjuvant to surgery for resectable colorectal cancer, Proc. XI International Cancer Congress, Florence, Vol. 3, 551, 1974.

18. Gunderson, L. L.: Role of radiotherapy on colorectal carcinoma. Reality and possibilities. Current Problems in Cancer, 1976, (in press).

19. Gunderson, L. L. and Sosin, H.: Areas of failure found at re-operation (second or symptomatic look) following "curative surgery" of the rectum: Clinicopathologic correlation and implications for adjuvant therapy, Cancer, **34:**1278-92, 1974.

20. Hahn, R. G., Moertel, C. G., Schutt, A. J. and Bruckner, H. W.: A double blind comparison of intensive course 5FU by oral vs intravenous route in the treatment of colorectal carcinoma, Cancer, **35:**1031-1035, 1975.
21. Higgins, G. A. and Dwight, R. W.: The role of preoperative irradiation in cancer of the rectum, Surg Clinics of North America, **52:**847, 1972.
22. Higgins, G. A., Dwight, R. W., Smith, J. V., Keehn, R. J.: Fluorouracil as an adjuvant to surgery in carcinoma of the colon, Arch. Surg., **102:**339-343, 1971.
23. Hollinshead, A., Glew, D., Bunnag, B., et al: Skin-reactive soluble antigen from intestinal cancer-cell-membranes and relationship to carcinoembryonic antigens, Lancet, **1:**1191-1195, 1970.
24. Horton, J., Hacker, B., Cunningham, T. J. C. and Sponzo, R. W.: The chemotherapy of large bowel cancer. Present status and future prospects, Am. J. Digestive Diseases, **19:**1040-1046, 1974.
25. Jansson, B., Seibert, G. B. and Speer, J. F.: Gastrointestinal cancer—Its geographic distribution and correlation to breast cancer, Cancer, **36:**2373-2384, 1975.
26. Kligerman, M. M., Urdenata, N., Knowlton, A. H., et al, Preoperative irradiation of rectosigmoid carcinoma including its regional lymph nodes, Amer. J. of Roent, Rad Therapy and Nuc. Med., **114:**498-503, 1972.
27. Kraske, P.: Zur exstirpation hochsitzenden mastdarmkresbse. Verh. dtsch, Ges. chir, **14:**464, 1885.
28. Levin, D. L., Devesa, S. S., Godwin, J. D., Silverman, D. T.: Cancer rates and risks, 2nd Ed. U.S. Dept. of HEW, p. 91, 1974.
29. Localio, S. A. and Eng, K.: Malignant Tumors of the Rectum. Current Problems in Surgery, Year Book Medical Publishers, Chicago, Sept. 1975.
30. Manheimer, L. H. and Vital, J.: Mitomycin-C in the therapy of far-advanced malignant tumors, Cancer, **19:**207-212, 1966.
31. Mavligit, G. M., et al: Adjuvant immunotherapy and chemoimmunotherapy in colorectal cancer of the Dukes' C classification — Preliminary clinical results. Cancer, **36:**2421-2427, 1975.
32. Moertel, C. G.: Therapy of advanced gastrointestinal cancer with the nitrosoureas, Cancer Chemotherapy Rep (Part 3), **4:**27-34, 1973.
33. Moertel, C. G., Schutt, A. J., Hahn, R. G. et al: Therapy of advanced colorectal cancer with a combination of 5-fluorouracil, methyl-1, 3-bis (2-chlorethyl)-1-nitrosourea and vincristine, J. Nat. Cancer Inst., **54:**69-71, 1975.
34. Ota, K., Kurita, S., Hishimura, M., et al: Combination therapy with mitomycin C (NSC 26980), 5 fluorouracil (NSC 19893) and cytosine arabinoside (NSC 63878) for advanced cancer in man, Cancer Chemother Rep., **56:**373-385, 1972.
35. Papillon, J.: Intracavitary irradiation of early rectal cancer for cure: A series of 186 cases, Cancer, **36:**696-701, 1975.
36. Quan, S. H.: Preoperative radiation for carcinoma of the rectum, New York J. Med., **66:**2242, 1966.
37. Quan, S. H., Deddish, M. R. and Stearns, M. W.: The effect of preoperative roentgen therapy upon 10 and 5 year results of surgical treatment of cancer of the rectum, Surg. Gynec. Obstet. **111:**507, 1960.
38. Rider, W. D.: Radiotherapy for rectal cancer. Program Am. Soc. Therapeutic Radiologists, p. 89, Oct 1975 (abstr.).
39. Silverberg, E., Holleb, A.: Cancer Statistics 1974 — Worldwide epidemiology, Ca. **24:**1:1-64, 1974.
40. Spratt, J. S. and Spjut, H. J.: Prevalence and prognosis of individual clinical and pathologic variables associated with colorectal carcinoma, Cancer, **20:**1976, 1967.
41. Turnbull, R. B., Jr., Kyle, K., Watson, F. R., et al: Cancer of the colon: The influence of the no-touch isolation technic on survival rates, Cancer, **18:**82-87, Mar-Apr. 1968.
42. Zamchek, N.: The present status of CEA in diagnosis, prognosis and evaluation of therapy, Cancer, **36:**2460-2468, 1975.
43. Zamchek, N. et al: Prognostic factors in colon carcinoma, Human Pathology, **6:**31, 1975.

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ALCOHOL USE AND ALCOHOLISM TREATMENT

Part I Concept

Part II Management of Detoxification Phase I

PAMELA PARRISH, MD

Pertinent information and guidelines for treatment of acute and subacute phases of alcohol detoxification. These include environmental factors, triage criteria, ambulatory and hospitalization regimes, and responsibility for continuum of care.

PART I

TREATMENT PHILOSOPHY

The treatment of symptomatic alcohol use and alcoholism is based on the concept that an individual having such pharmacological effects is in need of health care. The two primary bases for such recognition are:

1) personality deficiencies which may be produced by various etiological factors, and

2) pathophysiologic effects of alcohol and/or other organic abnormalities.

These components are intrinsically interrelated and present in altered proportions and manifestations dependent on the state of intoxication or sobriety.

The complexity of the etiological factors in alcohol dependence and its insidious pharmacological effects creates early an unawareness and the denial of difficulty by the individual. Later, recognition of failing defenses, rationalization, and life losses promote increased misuse to avoid reality and depression.[1] External pressure or internal desire or need may eventually lead the individual to seek health care.

GOALS OF TREATMENT

The comprehensive treatment plan must encompass all areas in which the alcohol user is having dysfunction: 1) social, 2) economic, 3) legal, 4) marital, 5) physical, 6) spiritual, 7) psychological. Attention to this requires coordination of a variety of skilled persons and facilities. Knowledge of and liaison with such resources is essential to the provision of continuity of care and the total rehabilitation of the individual, which is the goal to be sought.

HEALTH CARE ENVIRONMENT

The most important influences in achieving such a goal are the attitudes of the patient and health care persons and their interaction. This contact represents for the alcohol misuser a life crisis; motivation for cooperation and establishment of a treatment relationship is then optimal. The family or significant person is actively engaged in the information gathering and planning for the patient. They are also

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Alcohol and Drug Problems Association of North America, Chicago, Illinois, September 15, 1975.

aided toward dealing with their own attitudes.[2]

Health care persons in this treatment arena need to be carefully selected, and have or are capable of developing the following qualities and skills:

1) knowledge of the evolutionary process and manifestations of alcohol use and alcoholism,
2) psychological skills as:
   a) encouragement of expression of problems
   b) reduction of anxiety and fear
   c) consistent respect for the client's self-esteem
   d) constructive utilization of the patient's dependency
   e) active gratification of requests when they are therapeutically appropriate
   f) resolution of frustrative situations
   g) assistance toward a continuing treatment relationship, with its availability when needed[1]
3) personal concern and warmth
4) a non-judgmental and honest attitude toward patient[3,4]

Thus the individual can be helped to one of the appropriate phases of treatment.

PART II

PHASES OF TREATMENT IN ALCOHOL USE AND ALCOHOLISM[5,6]

I	Acute	Detoxification
II	Subacute	Management of the subacute and chronic medical and psychiatric conditions associated or unassociated with alcohol use to effect optimal general health
III	Long term	Rehabilitative alcoholism program with comprehensive services for resolution of psychosocial conflicts and psychological treatment including the drug dependency

PHASE I — ACUTE — DETOXIFICATION

Goals

1) Detoxification *per se* is the process of interruption of chemical intake, assistance of recovery from the psychological effects of acute intoxication or addictive withdrawal, and the prevention of hazardous behavior toward himself or others. These objectives are achieved by provision of prompt accessibility to detoxification services, and close interaction between such, and referral sources and resources.[4]

2) Management of phase II, the subacute and chronic medical and psychiatric conditions, is initiated during detoxification and may be completed during this period depending on the facility. Also the individual is assisted to communicate with skilled persons or agencies to cope with other urgent related problems, as fiscal, housing, legal, etc, thus lowering barriers to improved functioning on his departure.[2]

3) Psychological support for the alcohol misuser, the family, or significant persons is an integral component in the detoxification management.

4) The ensuing rapport with the health care persons abets introduction to an outpatient or inpatient rehabilitative program, phase III of treatment.

Types of Detoxification Services

1) Comprehensive, interdisciplinary, medical and psychiatric specialized units in general hospitals.

2) Non-segregated detoxification care in general hospitals.

3) Free standing units with limited medical services having relationship with a nearby physician or general hospital.

4) Non-medical short term emergency care with minimal medical supervision.[7,4,8]

DRUGS AND THEIR APPLICABILITY IN DETOXIFICATION

1. Goals

a) Therapeutic interruption of the pathophysiological effects in some categories of alcohol use and alcoholism is accomplished by the judicious use of medications.[9] The triage criteria and prediction guide for withdrawal syndromes[10] delineate the appropriate applicability of drugs as to the prevention or treatment of the particular condition.

b) Prophylactic treatment in anticipated withdrawal syndromes with time limited and regularly administered benzodiapezines results in the absence of withdrawal symptoms or lack of progression into their severe complications. Early ambulation, lower dosage, immediate oral liquid and food intake, less intensive and costly medical care, and a rapid movement into phases II and III of treatment also are positive results.

c) Other drugs are prescribed adjunctively when needed to assist the detoxification process and/or for other conditions.

2. Drugs and Their Uses

a) Benzodiapezines

1) Factors in Dosage Determination are:

a) The potential of or in one or more of the withdrawal stages

b) The degree of severity of symptomatology

c) The increase of drug resistance with smoking

d) The greater sensitivity with age or low serum albumin[11]

e) The individual and his alcohol consumption[3]

2) Advantages

The benzodiapezines have relatively minor risk of over-sedation, less addicting qualities, lack of seizure potentiation, and infrequent hepatic toxicity.[11,16]

3) Chlorodiazepoxide (Librium)

Chlorodiazepoxide has been widely accepted for treatment of the withdrawal syndromes, limiting development of delirium tremens to two per cent and convulsions to one per cent.[12,13] The oral route has better absorption in an empty stomach than intramuscular administration.[14,15] There is significant cross drug dependency with alcohol which apparently influences its efficiency.[12]

4) Diazepam (Valium)

Diazepam may be substituted for chlorodiazepoxide, having seizure inhibiting qualities. It is the preferred drug for control of the violent or convulsing patient, being given intravenously.[17] Its oral and intramuscular absorption is similar to chlorodiazepoxide.[15]

b) Hydroxyzine (Vistaril)

Hydroxyzine or other anti-emetic preparations are valuable short term substitutes for benzodiapezines to curtail nausea and vomiting, and speed resumption of oral intake.

c) Intravenous fluids

Intravenous fluids are indicated only with dehydration from emesis, diarrhea, limited oral intake, electrolyte imbalance, or other specific medical complications.[18]

d) Fructose

Fructose is valuable in treatment when given orally as fruit juice. Administered intravenously, two liters of a 10% solution over a 12-hour period will accelerate the metabolism of alcohol by 25%.[19] Caution is required due to fructose side effects, sensitivity in some individuals,[20] and the necessity for good liver function.[21] This may be used in acute alcohol intoxification[19] and delirium tremens, reducing duration of the latter.[22]

e) Phosphates

Hypophosphatemia with a serum level of 1.0 mg % or less necessitates treatment; a serum level of .5 mg % is considered an emergency. Potassium phosphate, two milliequivalents/cc (30 cc vial) in saline, is given intravenously when there is adequate renal function and a low serum calcium. Antacids containing aluminum are to be avoided.[11]

f) Magnesium sulfate

This drug intravenously raises the photic threshold when given in amounts of two to six grams, thereby lessening the convulsive potential in the withdrawal process.[23] With convulsions secondary to alcohol withdrawal or a serum magnesium less than 1.3 mg%, routinely administer two cubic centimeters of a 50% solution intramuscularly every six hours for 24 to 48 hours to attain a normal level. Otherwise, magnesium levels somewhat less than normal during the initial period of abstinence will remit spontaneously.[18,24-27]

g) Vitamins

Multivitamins are routinely prescribed. Thiamine in the dosage and route noted below may adjunctively assist in reduction of delirium tremens and seizures.[13,28]

The neurological complications of alcoholism are routinely treated daily for an extended period.

B_1 Thiamine	100 mg	IV or IM	3 days, then oral
B_6 Pyridoxine	50 mg	oral	

Other vitamins may be added daily with indication.[25]

B_3 Niacin	3 grams	oral	(Neuropathies)
B_{12} Cyanocobalamin	1000 mcg	IM	2 weeks (low serum)
C Ascorbic acid	3 grams	oral	(collagen synthesis)

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h) Diphenylhydantoin (Dilantin)

Diphenylhydantoin pharmacologically promotes egress of sodium from neurons and thereby raises seizure threshold.[29,30] Generally, there is no indication for its use in the prevention or treatment of the alcohol withdrawal convulsion syndrome when adequate prophylaxis and dosage of a benzodiapezine is prescribed.[31] In special associated conditions for which the drug is indicated, it should be added to the detoxification regime. With a prior history of repetitive seizure activity during withdrawal or brain injury, consideration is given to its addition.

The efficacy of diphenylhydantoin is controversial unless given in loading doses to achieve a therapeutic blood level of 1-1.5 mg%, if the individual was not previously medicated. An oral loading dose of 1.0-1.2 grams (5-7 mg/Kg) attains such a level in two to six hours. Gastric and cardiac symptoms can be avoided by giving the divided dosage in 12-24 hours. Intravenous dilantinization is only done selectively with acute recurrent seizure activity.[32] With the usual dose of 300 mg daily, a blood level of .03-.04 mg % is achieved during the first 72 hours and 1-1.5 mg % in 5-15 days.[32] Despite the lower levels, the latter regime has been shown to aid in limiting seizure activity.[28,33]

Diphenylhydantoin also alters insulin secretion by inhibition of its release after a glucose load. The fasting blood level remains normal and the curve becomes elevated. The drug thereby could reduce the possibility of hypoglycemia.[34]

i) Dexamethasone (Decadron)

This synthetic adrenocortical preparation promotes cerebral edema diuresis and improves relative adrenal insufficiency unless the organ is permanently impaired.[23,35] Rarely is dexamethasone used.

3. Specialized Treatment

Such is undertaken depending on the particularly complicating conditions.

EVALUATION CRITERIA

1. Intake History and Observations

This consists of: a) the essential data from the individual and/or others; b) a record of abnormal physical and mental signs and their degree of severity

The following format serves as an example:

PAST ALCOHOL USE HISTORY: DATE: SEX: AGE: RACE: MONTH: DAY: BIRTH YEAR:

Age started: Drinking a Problem (age)
Precipitating causes:
Usual Intake: (Kind and Amount)
Pattern: Daily Weekend Episodic On Job Alone With Others
Loss of Control: Time Amount
Blackouts: DTs: Convulsions:
Depression (degree): Suicidal (when, how): Homicidal (when, how):

CURRENT ILLNESS AND STATUS:

Last Alcohol Intake: Kind Amount Pattern
Date Hour Past 12 hours: Vomiting Diarrhea
Food Intake: Hallucinations: Convulsions
Current Mood:
Drug Misuse (other):
Other Medical Problems:
Prescribed Medication:

Occupation: Type Current
Marital Status: Current Marriages Total Number of Children
Spouse's program participation
Address:
Current Legal Problems:
Current Residence:
Current Financial State: Monthly Income:
OP Detoxification: _____ Routine prescriptions: Librium _____ Phenobarb _____ Dilantin _____
Referral source:
Current Alcohol Treatment (AT) Status:
Number Prior Admissions For AT (after regular/irregular discharge)—Recidivism:
OP _____ InP _____ Other: _____
Observation:

2. Toxicology

The blood alcohol level is a helpful assessment with other clinical information in triage and treatment. This technology may not be available in the initial contact.

3. Withdrawal Symptomatology Aspects:

a) Factors of the degree of severity of withdrawal depend on: 1) individual susceptibility, 2) abruptness of abstinence, 3) amount ingested, 4) duration and pattern of alcohol intake.[3] An individual, generally with a consistent consumption of one pint or more of a distilled beverage or its equivalent for five to seven days will be symptomatic.

b) Prediction Guide for Alcohol Withdrawal Symptoms[10]

Syndrome	Amount	Days Duration Intake	Peak of Symptoms
Acute Brain Syn.	1 pint 1 fifth	2-10 2-3	24 hours
Alcohol Hallucinosis	1 pint 1 fifth	11-21 4-7	24 hours
Delirium Tremens	1 pint **1 fifth**	21+ **10+**	**3-4 days**
Convulsions			**24 hours**

(90% occurred within 48 hours)

4. Medical Evaluation

With a history or evidence of recent trauma, moderate to severe depression or aggressive behavior, prior mental disorder, concomitant drug abuse, and acute or subacute physical complaints, appropriate medical evaluation and treatment is indicated. The mild to moderate symptoms of alcohol-related disorders respond to abstinence and conservative general measures; they do not require immediate special diagnostic procedures, ie gastritis, fatty liver degeneration, etc.[30]

TRIAGE AND MANAGEMENT

Utilizing the preceding information regarding the patient, the symptomatic alcohol user can be triaged by the health care person into one of the following categories and appropriately managed.

ALCOHOL ACUTE INTOXICATION

1. Mild to Moderate Effects

Generally this alcohol user may have been consuming approximately a half-pint to one pint or its equivalent, a few days or episodically, experiencing mild to moderate effects, and his condition is uncomplicated. The blood alcohol level may range from .06 to 0.2 mg %. No treatment for recovery is usually required other than time for the metabolic process to reduce his blood alcohol level and the after effects are not serious. If he is considered mentally competent and cooperative, he can return home without medicinal treatment. The more intoxicated individual may require a home, friend, or family, or non-medical recovery station to supervise his detoxification. An individual who is homeless may require assistance to other helping agencies. Education on alcohol use and counseling is offered that individual. Those persons in this category frequently pres-

ACUTE ALCOHOL INTOXICATION TRIAGE

Blood Alcohol Level mg%	Symptomatology	Patient Attitude	Alcohol Intake (Non-Habitual)	Self or Supervisory Resources	Type of Detoxification Program
.06-1 .1-.2	Minimal Moderate	Cooperative	Limited Moderate	Self Supervisory	None or Ambulatory
.06-.2	Violent: Potential or overt	Threatening or Assaultive	Limited to Moderate	Supervisory	Crisis intervention, Medical/ Law; then disposition
.2-.3	Stupor	Incompetent	Heavy	Supervisory	Hospital
.3-.4 or less	Coma	Incompetent	Heavy and/or Recent Abstinence	Supervisory	Hospital
	Moderate Complications Medical or Psychiatric	Cooperative or Incompetent	Limited to Heavy	Supervisory	Medical Evaluation

ent with complications, and further evaluation may be medically indicated.[3]

2. Violent Effects: Potential or Overt[36,37]

a) Immediate causes of aggression

1) "alcoholic and/or other drug intoxication
2) criminal action related to the desire to obtain drugs
3) episode of mental illness, including paranoia, agitated depression, catathymic crisis
4) physical illness
5) brain injury"[38]
6) alcohol pathological intoxication (*mania a potu*), an aberrant reaction,[39] is associated with temporal lobe damage and a low blood alcohol level.

"Categories 2, 3, 4 and 5 may include superimposed alcohol intoxication that renders a differential diagnosis at times difficult as to basic etiology or complication."[38]

b) Steps in management of potential violence:

1) "awareness of precursive signs — agitation, threatening verbalizations or gestures
2) withdrawal of objects or people from the environment which appear to frighten the individual
3) allowance of distance between the patient and the examiner
4) provision of reassurance; expression of an attitude of helpfulness and calmness
5) if the individual expresses fear that he will commit a violent act, evaluate how real the danger is and initiate steps to avert it."[38]

c) Steps in management of overt violence:

1) "summon immediate emergency help, trained personnel to act as a show of force or to restrain the patient
2) determine if medication is necessary
3) historical data as to intake of hallucinogenic drugs, other medication, physical illness or prior emotional illnesses
4) assess whether further violence will occur
5) decision as to the necessity for hospitalization
6) prescribe or administer medication or other treatment suitable for the patient."[38]

3. Stupor

Hospitalization and appropriate medical evaluation, incuding routine laboratory studies and toxicology, is necessary. This requires observation and careful differentiation from many other causes of stupor. The blood alcohol level may be helpful, usually ranging from 0.2 to 0.3 mg %, but should not be accepted as the only diagnosis because of the frequent occurrence of concomitant head trauma, infection and other conditions. Sedation and the use of tranquilizers should be avoided.[3] Cautious use of intravenous fructose can be considered.

4. Alcohol Coma

This is considered an emergency state because of the possibility of respiratory depression and circulatory impairment. The blood alcohol level usually ranges from 0.3 to 0.4 mg %. The condition is completely reversible if appropriate expeditious intensive measures are undertaken until the blood alcohol level decreases. Other causes of coma need to be ruled out through history from family or friends, together with physical examination. Before any medicinal therapy, 50 cc of venous blood is drawn for routine hematological, biochemical, and toxicological studies. With possibility of respiratory embarrassment and/or gastric lavage, endotracheal intubation is required to assist respiration in the former case and to avert aspiration in the latter.[3] Establishment of intravenous routes, using cutdowns or subclavian vein catheterization if necessary, is especially imperative with circulatory impairment. 50% glucose 50 cc must be given intravenously to prevent possible brain damage in the event this be hypoglycemic coma, even when another cause for coma is evident.[17]

DETOXIFICATION TREATMENT PROGRAMS

AMBULATORY DETOXIFICATION PROGRAM

One or more components of this ambulatory care program may be used in the patient's management dependent on the triage criteria.

1. Education

Education regarding alcohol use, its effects, and the potential of the development of alcoholism is offered. This may be the only service required for those in the acute alcohol intoxication group.

2. Rehabilitation

Rehabilitative treatment is immediately initiated for the alcoholism category by regular psychotherapeutic or counselling sessions and/or referral to a concerned person or agency

ALCOHOLISM TRIAGE

Diagnosis and Stage	Potential or Overt Physiological Symptoms	Patient Attitude	Alcohol Intake Habitual or Episodic	Self or Supervisory Resources	Type Detoxification Program
Non-addiction Early or	Minimal with Intoxication or Abstinence	Cooperative	Limited	Self or Supervisory	Ambulatory
Middle	Moderate with Intoxication or Abstinence	Cooperative	Moderate	Supervisory	Ambulatory
Addiction Middle or	Minimal with Intoxication or Acute Brain Withdrawal Syndrome	Cooperative	Moderate	Supervisory	Ambulatory
Late	Moderate to Severe of Withdrawal Syndromes	Cooperative or Incompetent	Moderate to Heavy	Supervisory	Hospital
Non-Addiction and Addiction Any Stage	Minimal Complications: Medical or Psychiatric	Cooperative	Limited	Supervisory	Ambulatory and Medical Consultation
	Moderate to Severe as Above	Cooperative or Incompetent	Limited to Heavy	Supervisory	Hospital

near the patient's residence. Education is an integral facet of any rehabilitation. Multiple supportive services may be comprehensively utilized depending on the variety of elicited problems, phases II and III of treatment.

3. Medical Detoxification

a) Criteria

1) Ambulatory detoxification with medication is considered for those with potential or overt physiological symptomatology who are either cooperative intoxicated individuals with a daily intake from one pint to one fifth of a distilled alcohol beverage (or its equivalent) the prior five to seven days, or those addicts with impending or mild manifestations of the withdrawal acute brain syndrome.
2) No undue medical or psychiatric complications.
3) Absence of recurrent recent vomiting and/or diarrhea.
4) A significant person or facility for patient supervision, or the individual deemed capable of adhering to instructions.

b) Medical Regime

With the above considerations, the withdrawal process can be safely accomplished by the prescribing of medications of low dosage and limited number utilizing the following guidelines.

THE PREVENTION OR PROGRESS OF COMPLICATED WITHDRAWAL SYMPTOMS IS ACCOMPLISHED BY MEDICATION ADMINISTRATION AS RAPIDLY AS APPROPRIATE AND WITH REGULARITY.

AMBULATORY DETOXIFICATION
MEDICAL REGIME

1. ALCOHOL INTAKE

Commit yourself to no further alcohol intake of any kind.

DETOXIFICATION CANNOT OCCUR WITHOUT ABSTINENCE.

2. HELP FROM OTHERS

Seek the assistance of one or more persons (relative, wife, friend, church group, AA, other) to supervise your medications and support your emotional and living needs. Your sincere request will usually be met by a helpful attitude by others.

Return to outpatient counselling meeting at scheduled appointment.

3. MEDICATION

DANGER — DO NOT TAKE ANY PRESCRIBED MEDICATION AND USE ALCOHOL.

Take all medications as prescribed unless adverse reactions occur; in such instances phone for advice.

Minor Tranquilizers

To reduce withdrawal effects start first capsule *no sooner* than four-six hours after your last drink.

1-5 days	Librium (25mg)	1 capsule	AM	Noon	Supper	Bedtime
6 day		1 capsule	AM			Bedtime
7-8 days		1 capsule				Bedtime

Other Drugs

These may be prescribed to reduce possibility of delirium tremens and/or convulsions in the alcohol dependent consuming one-fifth daily or its equivalent and who will not be receiving heavy dosage of minor tranquilizers.

1-3 days	Phenobarbital (30 mg)	1 tablet	AM	Noon	Bedtime
	Dilantin (100 mg)	1 capsule	AM	Noon	Bedtime

Other Medication

1-7 days	Multivitamin	1 capsule	AM	Bedtime
7-	indefinitely		AM	Bedtime

4. LIQUID AND FOOD INTAKE

Initially, drink fruit juice and milk as tolerated. Eat soft or solid foods at *regular* meal times and bedtime *whether desired or not.*

Continue fruit juices or fresh fruit between meals *for the next two weeks,* and *whenever* shakiness or alcohol craving develops.

Limit regular coffee to four cups daily; use decaffeinated type for any additional amounts.

All other alcohol misusers ineligible for ambulatory care or addicts with moderate to severe withdrawal manifestations constitute this triage category. Such, ordinarily, are medically urgent or emergent conditions requiring immediate hospitalization, evaluation, and treatment. One or more treatment components may be utilized.

1. Medical Detoxification
   a) Medical and Nursing Aspects
      Medical and psychiatric history together with physical examination, appropriate laboratory and diagnostic studies, consultation as indicated, and good nursing care should be a commonality for treatment of all.[40] Subdued light, attention to liquid and caloric intake, fecal and urinary output, and vital signs on a regular basis is routine the first 72 hours. Ambulation is encouraged and the patient assisted to this state by attentive nursing care in the debilitated.
   b) Nutrition
      Initially, fruit juice and milk is forced diet as tolerated.
   c) General Medications
      Daily vitamins are routinely prescribed and a non-aluminum-containing antacid given as needed.
   d) Rehabilitative medicine services may augment ambulatory effort in the more

HOSPITALIZATION DETOXIFICATION MEDICATION REGIME

No sooner than 4 hours and by 6 hours from last alcohol intake initiate the following:

DAILY INTAKE OR EQUIVALENT	DRUG	DOSE METHOD	DAILY FREQUENCY	TREATMENT PERIOD
UNCOMPLICATED: Acute Brain Syndrome, mild-moderate				
1 pint	Chlorodiazepoxide	25 mg 0	qid	5 days
5th-1 qt.	Chlorodiazepoxide	50 mg 0	q4-6h	1st 2 doses
	Chlorodiazepoxide	25 mg 0	qid	5 days
	Chlorodiazepoxide	25 mg 0	q4h prn additionally	5 days
COMPLICATED: Acute Brain Syndrome, severe; Impending/Active Delirium Tremens; Convulsion recent/current;				
1½ qts.+	Chlorodiazepoxide	50 mg 0-IM*	q4-6h	1st 24 hours
	Chlorodiazepoxide	50 mg 0	qid	2nd 24 hours
	Chlorodiazepoxide	25 mg 0	qid	3rd-7 days
	Chlorodiazepoxide	25 mg 0-IM*	q4h prn additionally	

*0 with empty stomach; IM if solid food ingested the prior 2 hours.

Nausea/Vomiting: In lieu of Chlorodiazepoxide:				
	Hydroxyzine	50 mg IM	q6h prn	1st 3 days
	Thiamine	100 mg IM	daily	1st 3 days
	Thiamine	100 mg 0	daily	27 days

severely handicapped. Other specialized medical consultation and treatment is provided as indicated with referral for continuum of care for chronic conditions, PHASE II of detoxification.

2. Medication Regime

   The potential or overt withdrawal symptoms, their severity, or the degree of complications determine the basic medication and dosage as in the suggested guidelines. Prophylaxis is the watch word for medical detoxification.

   Additional drugs may be added as applicable to specialized conditions of withdrawal or otherwise.

3. Rehabilitation

   a) Psychological support is initially provided by nursing and physician contacts. With improvement, daily counselling sessions with the staff together with informal discussion with the abstinent rehabilitating or recovered alcoholics provide the bases for interest and commitment of the patient to continued treatment.

   b) Education regarding alcohol effects and alcoholism is initiated.

   c) Individualized planning for in-patient discharge with referral toward comprehensive alcoholism treatment when propitious, PHASE III, finalize the goals of the detoxification process.

REFERENCES

1. Hayman, M.: Alcoholism, mechanism and management. Thomas, 1966.
2. Mardones, J., Israel, Y.: Biological basis of alcoholism. Wiley Interscience, 1971.
3. Anderson, R. Weisman, M.: The alcoholic in the emergency room. NCA.
4. Ottenberg, D. J.: Detoxification in a comprehensive alcoholism treatment program. NIAAA, March 24, 1972.
5. Damstra, D. L.: Current approaches to treatment. September, 1973.
6. Oklahoma State Nurses Assoc. Alcohol Education Program. State Handbook: Alcohol use, alcohol abuse. Alcoholism Handbook, 1974.
7. Briant, R. G.: Social setting detoxification. Alcohol Health and Research World, Winter, 1974.
8. Seixas, F. A.: New priorities in diagnosing and treatment alcoholism. Industrial Medicine and Surgery, March, 1973.
9. Golbert, T. M., Sanz, C., Rose, H. D., Leitshuh, T. H.: Comparative evaluation of treatments of alcohol withdrawal syndromes. JAMA, 201, No. 2, July 10, 1967.
10. Victor, M.: Withdrawal, neurological syndromes, and EEG. Annals N.Y. Academy Sciences, **215:**210-213, 1973.
11. Becker, C.: Clinical problems in diagnosis and management of withdrawal. ADPA San Francisco, Calif., 1974.
12. Kaim, S. C.: Optimal therapy of alcohol withdrawal state. Current Psychiatric Therapies, Vol. 10, 1970.
13. Kaim, S. C., Klett, J.: Treatment of delirium tremens: A comparative evaluation of four drugs. VA Cooperative Study. August, 1971.
14. Greenblatt, D., Shader, R. J., Koch-Wese, J.: Slow absorption of intramuscular chlorodiazepoxide. New England Journal of Medicine, Vol. 291, No. 21, 1974.
15. Greenblatt, D., Shader, R.: Drug therapy benzodiazepines (2 parts). New England Journal of Medicine, Vol. 291, No. 19 and 23, 1974.
16. Greenblatt, D., Shader, R.: Benzodiazepines in clinical practice. Raven Press, 1974.
17. Greenblatt, D., Shader, R.: Drug abuse and the emergency room physician. American Journal of Psychiatry, **131:**559-562, 1974.
18. Beard, J., Knott, D.: Fluid and electrolyte balance during acute withdrawal in chronic alcoholic patients. JAMA, **204:**No. 2, 1968.
19. Friend, W. G., et al: Effect of fructose on delirium tremens. JAMA, **217:**474-475, 1971.
20. FDA Drug Bulletin, April-June, 1975, pp. 6-7.
21. Brown, S. S., Forrest, J. A. H., Roscoe, P.: A controlled trial of fructose in the treatment of acute alcoholic intoxication. Lancet, October, 1972.
22. Montgomery, F. A., Solowan, R.: Using fructose in the treatment of delirium tremens. Hospital and Community Psychiatry, Vol. 24, No. 12, Dec., 1973.
23. Wolfe, S., Victor, M.: Relationship of hypomagnesemia and alkalosis to alcohol withdrawal symptoms. Annals N.Y. Academy Sciences, 162, Part 2, 1969.
24. Flink, E. B., Stutzman, F. L., Anderson, A. R., Kong, T., Fraser, R.: Magnesium deficiency after prolonged parenteral fluid administration and after chronic alcoholism complicated by D. T. Journal of Laboratory and Clinical Medicine, **43:**169, 1954.
25. McNichols, R.: The treatment of delirium tremens and related states. Thomas, 1970.
26. Mendelson, J., Wexley, D., Kubzansky, P., Leiderman, P. H., Solomon, P.: Serum magnesium in delirium tremens and alcoholic hallucinosis. Journal of Nervous and Mental Diseases, **128:**352, 1959.
27. Wacker, W. E. C., Paris, A. F.: Magnesium metabolism. New England Journal of Medicine, **278:**658, 1968.
28. Rothstein, E.: Prevention alcohol withdrawal seizures: The roles of Diphenylhydantoin and Chlorodiazepoxide. American Journal of Psychiatry, **130:**12, 1973.
29. Finer, M. J.: Diphenylhydantoin in alcohol withdrawal. JAMA, 217, No. 2, 1971.
30. Finer, M. J.: Over-management of the alcoholic patient. JAMA, 219, No. 5, 1972.
31. Gessner, P.: Is diphenylhydantoin effective in the treatment of alcohol withdrawal? JAMA, 219, No. 8, 1972.
32. Easton, J. D.: Diphenylhydantoin and epilepsy management. Annals of Internal Medicine, **77:**421-423, 1972.
33. Sampliner, F., Iber, F.: Diphenylhydantoin control of alcohol withdrawal seizures. JAMA, Vol. 230, No. 10, 1974.
34. Buckley, R.: Diphenylhydantoin in the treatment of duodenal ulcer. JAMA, 219, No. 2, 1972.
35. Mullan, H., Sangireliano, I.: Alcoholism, Thomas, 1966.
36. Roche Report: Emergency Room: Evaluation and management of violent patients. Vol. 1, No. 20, 1971.
37. Hospital Physician: Managing violent patients in the ER. November, 1971.
38. West, L. J.: The violent patient, causes and management. Practical Psychiatry, Vol. III, No. 3, 1974.
39. Criteria Committee, National Council on Alcoholism: Criteria for the diagnosis of alcoholism. American Journal of Psychiatry, **129:**2, 1972.
40. Seixas, F. A.: Treating alcoholics: A practical program for family physicians. Medical Times, Vol. 99, No. 7, 1971.

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News From The Oklahoma State Department of Health

Oklahoma's School Immunization Law, Title 70, Sections 1210.191 and 103, were amended during the 1976 Legislative Session and signed into law by Governor Boren on June 9th, 1976. The amended law contains three important revisions:

1. The amended law applies to all of Oklahoma's 640,000 minor children attending school in kindergarten through the 12th grade. Previously the Immunization Statute covered only those children entering elementary school for the first time.

2. The amended law removed the requirement for tuberculin testing of all children entering school for the first time.

3. The amended law broadened the authority for enforcement of the immunization regulations to include not only the Oklahoma State Department of Health but also the State Department of Education and the governing board to the school districts. (In addition to the statutory requirement, the State's Attorney General ruled on March 26th, 1976, that it is the "mandatory duty" of school officials to refuse admission to any school in the State of Oklahoma to any child who does not have their required immunizations.)

The amended law also provides that parents and guardians who are unable to pay for the required immunizations may receive these from the State Department of Health without charge. The exemptions to the Immunization Law on medical, religious or personal grounds remain unchanged.

The State Board of Health will be asked to delete the requirement for smallpox immunizations for all children and the rubella requirement for females over 12 years of age in its July, 1976 meeting.

The Immunization Program encourages all health care providers to review the immunization status of their preschool and school age patients to assure that they are in compliance to these new immunization statutes and to remind you that the 1976-77 school year will start in a little more than six weeks. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR JUNE, 1976

DISEASE	June 1976	June 1975	May 1976	Total To Date 1976	1975
Amebiasis	1	3	2	5	9
Brucellosis	1	—	—	3	3
Chickenpox	90	37	267	1514	924
Encephalitis, Infectious	—	4	5	10	19
Gonorrhea (Use Form ODH-228)	846	72	847	6012	6048
Hepatitis, A, B, Unspecified	75	—	109	815	447
Leptospirosis	—	—	—	—	—
Malaria	—	—	—	—	1
Meningococcal Infections	—	1	1	18	9
Meningitis, Aseptic	—	5	1	9	18
Mumps	28	18	123	627	149
Rabies in Animals	19	7	23	83	65
Rheumatic Fever	—	—	2	8	6
Rocky Mountain Spotted Fever	18	25	15	35	50
Rubella	1	2	7	48	82
Rubella, Congenital Syndrome	—	—	—	—	—
Rubeola	15	27	53	281	117
Salmonellosis	32	18	17	94	86
Shigellosis	5	12	28	133	167
Syphilis, Infectious (Use Form ODH-228)	10	4	9	56	45
Tetanus	—	—	—	—	—
Tuberculosis, New Active	32	37	22	175	173
Tularemia	1	3	5	6	5
Typhoid Fever	—	—	—	—	—
Whooping Cough	4	3	—	5	15

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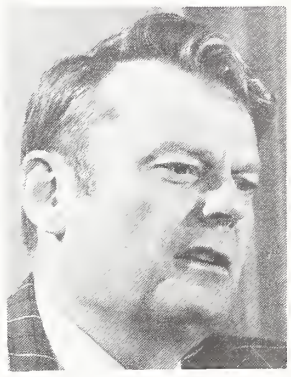
MEDICAL CARE COSTS

MAX H. PARROTT, MD

Immediate Past-President of the American Medical Association and Chairman of the AMA's new Commission on the Cost of Medical Care

No one really *enjoys* a medical bill.

Charges for the traditional necessities—food, clothing and shelter — can generate a degree of pleasure or fulfillment. But even the most glowing health report rarely evokes joy when the bill arrives. Medical payments, like taxes, create neither creature comforts nor ego satisfactions.



Max H. Parrott, MD

And when medical costs rise, as they have been doing, people display more than their customary frustration with such economic behavior.

In turning a clear eye on what has been happening to medical costs it is therefore well to skip over the emotional factors and focus on the hard facts.

The Consumer Price Index tells us that in the last five years the component for medical care has risen 39.8 percent, with physician fees increasing 39.5 percent. That is more, *but not dramatically more,* than the 38.6 percent rise for all items or the 37 percent rise for all services. The CPI ignores significant increases in the quality of care — new technology and more sophisticated treatments for disease, for instance. But it is still as good an indicator as we have. From 1970 to 1975 total US expenditures for health, which include everything from brain surgery to medicated shampoo, have grown from $69.2 billion to $118.5 billion, a jump of 71.2 percent.

Not a particularly welcome total. But just how do such boxcar figures translate into impact on a family budget? On the opposite page is a table showing what has happened to an intermediate family of four.

The intermediate family spent 6.5 percent of its after-tax income on medical care in 1970, 6.6 percent in 1975 — scarcely a dramatic surge.

What alarms many people about health care costs is not so much what has happened as what could happen. In 1975 medical care components rose at an annual rate of 12 percent on the Consumer Price Index, compared to 9.1 percent for all items and 9.5 percent for all services.

WHAT FUELS THE INFLATION?

There are no simple answers. But we can identify the more dynamic inflationary forces.

Health Insurance: No one knows whether we have a "free enterprise" health care system or a "socialized" system. But we know we have a highly regulated system. And we know we have an *insured* system. Insurance pays nine out of ten hospital bills, 65 percent of physician care expenses. Twenty-five years ago the patient paid about two-thirds of his medical expenses. Today he pays less than one-third in out-of-pocket costs.

Medical costs are a unique element in our economy. For every other purchase the American consumer uses his own earnings, savings or credit. But for medical "purchases" the con-

sumer generally does not act in the role of classic economic man, for he is not, by and large, spending his own money. Health insurance has removed or sharply modified one classic brake on demand — consumer price restraint.

By emphasizing hospital benefits rather than less expensive ambulatory care, health insurance exerts another upward pressure on cost.

Government programs: Medicaid, Medicare, and other government medical care programs add massive fuel to demand. These programs now sluice $50 billion annually into the health care system with expenditure controls that can hardly be described as taut.

To hold down costs, the federal government arbitrarily reimburses hospitals and physicians at rates determined by the experience of earlier years. To compensate, hospitals and physicians are under economic pressure to raise rates and fees more frequently. Government medical payments are thus *twice-subsidized,* first by taxes and then by increased charges to non-government patients. The effect is the familiar, upward spiral.

Wider eligibility and broadened benefits: These have also shot federal costs up. Without the passage of major health legislation, federal health expenditures have *doubled* since 1970. And without a major shift in the US economy, the number of people receiving Medicaid benefits, now 32.5 million, has *tripled.*

Even without any increase in prices in the last five years, government medical spending would have risen 45.2 percent.

Demographic changes: Changes in the population are working against medical care costs. The US is becoming not only a more populous nation but an older nation, and older people require more medical care. The oldest 10 percent of the population, accounts for more than 33 percent of inpatient hospital days.

Hospital costs: These costs exert tremendous impact, for they represent about 39 percent of all US health dollars (compared to the 19 percent for physicians, 9 percent for drugs and drug sundries, 8 percent for nursing home care and 6 percent for dentists). Demand factors, created by the growing availability of insurance, are principally to blame for the upward pull on hospital costs. In addition, hospitals have been hit by general inflation as few other segments of the economy. The market basket of things a hospital buys are items whose prices are increasing far *more* rapidly than the items measured in the Consumer Price Index. Hospital payroll costs — a large factor in a hospital budget — have gone from $33.16 per patient day in 1970 to $72.34 in 1975, an increase the consumer ultimately absorbs.

Malpractice: The premiums that physicians and hospitals pay for liability insurance are beginning to drive up costs. Rates for physicians have jumped 148 percent in Illinois, 168 percent in New York and as much as 400 percent for some doctors in California. Michael Reese Hospital (Chicago) now spends $3 per room per day on liability insurance. Next year it will be $16.50.

ARE CONTROLS THE SOLUTION?

Solutions, of course, are what we all are looking for. There seems to be no single, simple solution.

FAMILY BUDGET	1970	1975	$ change	% change
Before taxes	$10,664	$15,318	+$4,654	+43.6%
After taxes	8,744	12,427	3,684	42.1
SPENT FOR . . .				
Food	2,452	3,827	1,375	56.1
Housing	2,501	3,533	1,032	41.3
Transportation	912	1,279	367	40.2
Clothing, personal care	1,137	1,433	296	26.0
Other family spending	639	831	192	30.0
Charity, life ins., etc.	539	701	162	30.1
Taxes, etc.				
Social Security taxes	387	834	447	115.5
Income taxes	1,533	2,057	524	34.2
Medical Care	564	822	258	45.7

Source: U.S. Bureau of Labor Statistics

Controls, if they work at all, will only work longterm if prices *and* wages are controlled throughout the economy as a whole. New methods of delivering care should be tried. We have a pluralistic system now, and we should continue new approaches. Various forms of utilization review are in place, in development or under study. Closer agreement must be reached on how to plan effectively on a voluntary basis, cut duplication and distribute facilities more efficiently.

Physicians must better acquaint themselves with the cost of the procedures they order for patients, then take a flintier look at the cost/benefit ratio. They can make less costly decisions *if the threat of malpractice is better contained*. Review procedures, such as the current vogue for "second opinions," must be understood for what they may turn out to be: the denial of services desired by the patient or judged by his physician to be necessary.

THE MEDICAL TROIKA

The hard fact is that medical care costs have to be considered along with at least two other, equally important factors — the accessibility of medical care to the whole population and quality of the medical care given. These three dynamics — cost, access and quality — form a troika, a three-horse hitch in which the separate horses have to pull harmoniously to pull effectively.

Medical insurance — and especially government medical insurance — has vastly widened access. Very few people now fail to seek medical care because economic barriers block the way.

This emphasis on access, widely accepted as a desirable social goal, has led to more people seeing more physicians (whose numbers increased 18 percent between 1970 and 1975). The impact thus generated has inevitably fallen on the two other horses in the troika, cost and quality.

As far as quality is concerned, there has been no compromise. If anything, the quality of American medicine has improved.

The impact has fallen on cost.

POLICY AND THE PUBLIC

The question is really this: Which way does the American public want its medical care? There are three basic choices:

1. The US can have lower cost medical care and, at the same time, universal access to it *if* it is willing to limit the quality of the care given.

2. The US can have lower cost medical care and the present high quality of care *if* it is willing to limit access by shifting more of the financial burden back on the individual.

3. Or the US can provide universal access and the best medical care there is *if* it is willing to accept the high cost.

The third is the option Americans have chosen. I think it is the choice they will continue to make.

If that is the public's choice, then what can be done to bring costs into line?

Right now my feeling is that the best answer is in health education — better knowledge and *especially* better motiviation — applied to *personal* health decisions on diet, nutrition, tobacco, alcohol, exercise and emotional stress.

The American Medical Association is concerned along with everyone else over mounting costs. We have recently formed a Commission on the Cost of Medical Care, of which I am chairman. It is a diverse and representative group, not a committee of doctors only. We are concentrating on the basic aspects of the problem. I expect we will soon come up with practical approaches that can moderate costs without jeopardizing quality. □

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Council Activities Approved by Board of Trustees

An ambitious schedule of activities for the OSMA's six operational councils has been recommended by the new Council on Planning and Development and approved by the Board of Trustees. The planning council was established by the House of Delegates at its 1976 meeting to simplify the association's operational structure.

Members of the planning council are: the immediate Past-President (chairman); President; President-Elect; Speaker of the House of Delegates; Chairman of the Board of Trustees; Chairman of the six operational councils; and Delegates and Alternate Delegates to the American Medical Association.

The council is charged with studying and making "recommendations to the Board of Trustees and to the House of Delegates concerning the long-range objectives of the association, and will assess and make recommendations regarding the resources and programs necessary to reach these objectives."

The council met on July 10th and 11th and approved the following programs which were then approved by the Board of Trustees at its July 18th meeting. Each of the OSMA's operational councils is listed in order of consideration with a summary of its approved program.

Council On Professional And Public Relations

This council is charged with planning and conducting all activities of the association dealing with public relations and public service projects, interprofessional and intraprofessional relations.

The approved projects for the Council on Professional and Public Relations are:

*Continue publication of the monthly internal newsletter *"OSMA News."*

*Develop a membership folder describing the OSMA for distribution to current and new association members.

*Produce a folder describing the role of the Physicians Committee—the committee responsible for providing advice or counseling to physicians who seek or need it.

*Develop a Resource Library on principal medical issues.

*Create an awards system to recognize members of the news media for their contributions to accurate medical news reporting.

*Establish and/or perfect relations with the news media across the state.

*Work with state television stations in producing documentary films about the medical profession.

*Create an Advertising Committee to bolster *OSMA Journal* advertising.

*Complete *"Medical Update,"* the office placard for placement in physicians' offices.

*Produce a 30-minute documentary film emphasizing the public's stake in socialized medicine.

Council On Medical Education

The medical education council is responsible for maintaining or improving the level of medical competency in Oklahoma. Its duties include, but are not limited to, maintaining liaison with medical education colleges in Oklahoma, maintaining liaison with other health professions or occupations, conducting continuing medical education courses for association members, and accrediting medical education programs in Oklahoma.

The council's approved program of activities include:

*Developing a required continuing medical education program for OSMA members to become effective January 1st, 1978. At the same time, have the OSMA recognized as a CME accrediting institution. Prepare all necessary documents and manuals for this program.

*Monitoring the outcome of the Federal Health Manpower Act pending before Congress and making appropriate recommendations to the Board of Trustees regarding the Financial Aid to Education Committee, the Oklahoma Foundation for Community Medical Care, and the allocation of funds to these organizations.

*Investigating the possibility of endowing a "Professor of Continuing Medical Education" chair at the University of Oklahoma Health Sciences Center or the OU College of Medicine.

*Consideration of a partnership arrangement with the OU College of Medicine and perhaps its Alumni Association aimed at developing a sophisticated physician placement and recruiting service. This is necessitated by the termination of Federal funding to the Oklahoma Council for Health Careers.

Council On Medical Services

The duties of this council are to study and formulate activities with respect to the provision of adequate medical care. This responsibility includes the evaluation of all types of health care delivery systems, health planning, the social aspects of health, internal peer review mechanisms and the appraisal of all external programs which affect the cost or quality of medical care.

Approved activities for the Council on Medical Services include:

*The reappraisal of OSMA Peer Review activity in light of increasing costs in terms of money and time. This activity should be reorganized by the council to insure accountability to the public, to third party carriers, and to OSMA members.

*Develop contingency plans for establishing OSMA as a collective bargaining agent in case this activity is made necessary by government edict.

*Work within the confines of Federal law, PL 93-641 to acquire the greatest amount of medical input into health planning as is possible. The council should work for the maximum physician representation at the Subarea Council level.

*The council and its Laboratory Quality Committee should work to accommodate new federal legislation . . . such activity may prevent further federal intervention into this area.

*The council through its Emergency Medical Services Committee should advise the Governor on EMS matters, particularly in obtaining federal funding for planning start-up costs for a statewide EMS program.

Council On Governmental Activities

The Council on Governmental Activities is responsible for reviewing federal and state legislation and regulations and with initiating activities of appropriate response. The council is charged with establishing and maintaining relations with federal and state entities having statutory or regulatory jurisdiction affecting the medical profession.

The council's approved program includes:

*The examination of issues which potentially affect the medical profession . . . also



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the formulation of legislative proposals necessary to protect the profession and the public.

*The council shall closely monitor the malpractice insurance situation to determine if additional legislative efforts are needed.

*The examination of Oklahoma's Workmen's Compensation laws with the idea in mind of establishing a system where physicians would examine injured workers only on the basis of physical impairment in contrast to the present system where job disability ratings must be determined by physicians.

*The examination of the propriety and viability of forming a medical malpractice cooperative.

*The improvement of OSMA relations with the Oklahoma Congressional delegation.

*The establishment of better lines of communication with the Department of Health, Education, and Welfare in order to have more input into health planning.

*The establishment or improvement of relations with medical specialty societies, county medical societies, the OSMA Woman's Auxiliary, and with the Oklahoma Osteopathic Association in order to broaden the base of support for the OSMA legislative programs.

Council On Members Services

This council will assume responsibility for planning and carrying out services of all kinds which have direct benefit to association members and constituent county or district societies of the association. These duties include insurance benefit programs, special publications, travel programs, services to the Woman's Auxiliary, and student and house relations, speakers services, membership surveys, and membership recruitment.

Approved programs for the 1976-77 organizational year include:

*Continued work on the medical malpractice program including the investigation of the need for forming a malpractice cooperative.

*The promotion of the OSMA Physicians Committee in line with perfecting its referral system. To make this committee more functional, two-way interchange needs to be established between the OSMA and the Oklahoma State Board of Medical Examiners.

*Bolster OSMA grievance mechanisms in order to be more accountable to the public.

*Examine the actions of the Federal Trade Commission regarding physician advertising. If the AMA is forced to relax its constraints on advertising, the council will need to review follow-up action.

Council On Public And Mental Health

The Council on Public and Mental Health is responsible for representing the association in all matters related to public or mental health, including maintaining liaison with public or private organizations engaged in this type of activity.

Approved activities for the council include:

*Working with the State Department of Health in its massive flu vaccination program.

*The establishment of a Committee on Environmental Quality.

*Providing counsel, when requested to the State Department of Health on matters related to the Council's expertise.

The above mentioned OSMA councils will carry out the majority of the association's projects during the coming year. The projects mentioned for each council are projected and the councils' actual activities may, by necessity, change.

Chairmen for the councils are: M. Joe Crosthwait, MD, Council on Professional and Public Relations; Floyd F. Miller, MD, Council on Medical Education; William M. Leebron, MD, Council on Medical Services; Perry A. Lambird, MD, Council on Governmental Activities; C. Alton Brown, MD, Council on Members Services; and Stephen J. Adelson, MD, Council on Public and Mental Health. □

IN MEMORIAM

Stanley Kent Shields, MD
February 27th, 1943 — June 4th, 1976

Doctor Shields, who had been a member of the Chicksaha Clinic family for one and a half years, was a fine physician and a gentleman, in the highest meaning of that word. Even when his health was impaired, he graciously gave of his time to aid his patients and be concerned with their health problems. It is with a deep sense of gratitude for his wise and effective services that we mourn the loss of our good friend, Doctor Stan Shields.

CHICKASHA CLINIC STAFF

Oklahoma Utilization Review Project Granted "Conditional" Approval

Ed Kelsay

A one-year demonstration project for the Oklahoma Utilization Review System, known as OURS, has been conditionally approved by the Health, Education and Welfare Department. The ten conditions that must be met before the OURS project will be fully funded and become operational are all technical or procedural in nature and do not affect the working concept of the plan.

The OURS project grew out of a concern on the part of organized medicine that approximately 40 rural hospitals in Oklahoma could not meet the original Utilization Review Regulation requirements published on November 29th, 1974. In an attempt to work out a compromise via a regional review team system, it became obvious that the compromise could be the basis of a statewide Utilization Review Plan far more effective, less cumbersome, and less expensive than the original UR regulations.

The one-year demonstration project, when funded by HEW, will be carried out under the auspices of the Oklahoma Foundation for Peer Review, Inc. The foundation, created and controlled by Oklahoma physicians, has over 1,500 physician-members in Oklahoma.

One of the ten conditions outlined in the approval called for the publication of a special regulation by the Social Security Administration to permit Oklahoma hospitals to use the Demonstration Review System in lieu of the Utilization Review required by current Medicare regulations. The entire timing of the project hinges on the publication of the special regulation.

Once the special regulation is published and made final, funding of the project should take place within a matter of a few weeks. It will then take approximately two months, from the date funding is received, until the OURS project can become operational.

During this two-month period between funding and operations, it will be necessary for the Foundation for Peer Review to add four employees to its staff. The new employees will spend the first month putting the finishing touches on the necessary manuals and instructions for the Regional Review Teams and hospital Utilization Review Committees. It will also complete the necessary sub-contracts and agreements between the foundation and the Medicare and Medicaid fiscal intermediaries.

The second month after funding will be devoted to the training of the Review Coordinators to be located in each hospital and the familiarization of the hospitals' lay and professional staffs with the project itself.

During the past four months, ever since the project was first approved by the State Medical Association, Osteopathic Association, and Hospital Association, the staff of the OFPR has been traveling to hospitals and medical societies throughout the state and giving a special 30-minute program on the OURS plan.

The entire OURS project is based on the concept that most hospitals are already performing at an acceptable level and that additional utilization review requirements will not improve that level, but will simply be a vexation to the hospital lay and professional staffs.

A description of the OURS project accompanying a grant request to HEW stated that the objectives of the project are, "To establish that an objective and reliable retrospective audit system for hospital Utilization Review can be designed . . . for the purpose of problem identification, and that statewide and/or regional peer group supervision can effectuate expeditious problem solving of a permanent nature." It went on to state that the project will selectively reward institutions which meet certain standards by waiving or relaxing the review requirements. Hospitals that fail to comply with acceptable performance standards will be held to more stringent review requirements.

The OURS plan has developed a computer screening system to evaluate every hospital in the state for such things as length of stay, use of ancillary services, charges per day, and a number of previous Medicare and Medicaid denials.

If a hospital meets the established standards by staying within the computer parameters, its internal Utilization Review will consist primarily of meeting only the reporting requirements and will have a minimum of physician involvement. However, for the hospital falling outside the standards and parameters, the Utilization Review Requirements will be more stringent and will require more physician time.

All hospitals will be re-evaluated each quarter. The evaluation will be carried out by the

Regional Review Team consisting of nine physicians, a proportionate number of MD's to DO's as dictated by the physician population in the region. If a hospital in the region does not meet the standards in any given quarter, it will be so informed and given an additional quarter to correct deficiencies. □

Doctors Divided on Issue of Compulsory Service

Physicians are almost evenly divided on the question of whether young doctors who receive government loans or direct financial assistance to pay for their medical education should subsequently be required to serve for a period of time in medical shortage areas.

This was the finding of an American Medical Association poll reported in the May 24th issue of the Impact section of *American Medical News,* the AMA's weekly newspaper for physicians.

The poll found that 49.8 per cent of the doctors surveyed are opposed to such mandatory service in return for financial aid, while 45.4 per cent favor it. The others were undecided.

Among the physicians who voted for obligatory service in areas of medical need, older doctors (age 65 and over) are most strongly in favor (69.7 per cent). MDs in the 35-49 age bracket are least in favor.

When asked if they would require all graduating physicians — even those who had received no loans or financial assistance — to serve in shortage areas, 87 per cent of the doctors polled said no. □

Orthopaedic Society Elects Officers

The following officers were elected at the 1976 Annual Meeting of the Mid-Central States Orthopaedic Society; W. John Robb, MD, Cedar Rapids, Iowa, President; Worth M. Gross, MD, Tulsa, Vice-President/President-Elect; and Norman C. Bos, MD, Hutchinson, Kansas, Secretary-Treasurer. The meeting was held at the Lodge of the Four Seasons, Lake Ozark, Missouri.

The society's 1977 annual meeting will be held at the Roosevelt Royale Hotel, Cedar Rapids, Iowa, May 12th-14th. □

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Trustees Call Special Delegates Meeting

"In the interest of unity," the OSMA Board of Trustees, acting as the OSMA judicial council, has called for a special meeting of the House of Delegates to be held in October, 1976. The purpose of the meeting will be to reconsider House action taken at the annual meeting in April which makes AMA membership voluntary as of January 1st, 1977, but which requires the total amount of dues paid by OSMA members to remain the same.

After wrestling with the question of AMA dues and membership for several hours, the OSMA House of Delegates, at its annual meeting in April, approved an amended version of a Tulsa County resolution calling for membership in the national organization to be voluntary effective January 1st, 1977. In the amended and approved version, an OSMA member would not be required to belong to the AMA, but he would have to pay the equivalent of the dues charged by the national organization nevertheless. If he chose not to belong to the AMA, the $250 normally charged for AMA membership would be "equitably apportioned" between the OSMA and the county medical society.

When the Board of Trustees considered the House action, several procedural questions were raised. Additionally, the question of constitutionality was also considered by the Board.

The constitutionality of the action was eventually resolved by a favorable vote by the Board. However, the Board continued to debate what were considered to be procedural problems.

As the Trustees pointed out, the OSMA Bylaws require that all amendments to the Bylaws be introduced in writing at the opening session of the House of Delegates. This requirement, they said, was not met since the resolution from Tulsa County was amended at the closing session and in a manner which would require more amendments than were cited in the original resolution.

The Board also examined the potential divisive effect it felt the amended resolution could potentially have. Referring to Chapter V, Section 6.00 of the Bylaws which state, "The Board of Trustees shall endeavor to promote unity of purpose and friendly relations between all members and component societies of the association," the Board voted to call a special meeting of the House of Delegates in October, 1976, to reconsider the action taken regarding AMA membership.

The date and site for the special meeting of the House of Delegates will be announced at a later date. □

Lawyers Charged With Antitrust Violations

The US Department of Justice has formally charged the American Bar Association with restraining free trade. The charge is a result of the association's Code of Ethics which forbids attorneys from advertising fees and services.

The suit, filed in US District Court in Washington, D.C., charges that the ABA is in violation of the Sherman Antitrust Act and asked that the ethics code be voided. The suit claimed the ethics code has restrained fee competition among lawyers and deprived people needing legal service from the opportunity to get necessary or useful information on availability and cost.

The ABA's President, Judge Lawrence Walsh, said the 200,000 member voluntary organization "intends to resist this action."

"Although in some fields and as to some products, particularly uniform products, advertising as to price is useful, a heavy preponderance of lawyers commenting on lawyer advertising have felt it would not be useful. They are also concerned that advertising has in it the danger of deceit and overstatement."

In December, 1975, the Federal Trade Commission issued a similar complaint against the American Medical Association, the Connecticut State Medical Association, and the New Haven County Medical Society. The FTC complaint charged these groups with restraint of trade through ethical restrictions on physician advertising.

The AMA initially tried to have the complaint thrown out, but an FTC administrative judge rejected the request. The AMA has since issued a statement reaffirming and clarifying its ethical restrictions. The statement was printed in the April 19th issue of *American Medical News* and was reprinted in the July issue of the *OSMA Journal*.

A hearing on the FTC complaint against the medical association has been set for October 18th. □

AMA Officers



Richard E. Palmer, MD, Virginia
President
(left)
John H. Budd, MD, Ohio
President-Elect
(right)
Photo/Joe Fletcher/AMA

AMA House Debates — Endorses Medicredit Plan

After divided debate in both the reference committee hearing and on the floor of the House of Delegates, the AMA renewed its support for its brand of national health insurance while rejecting a proposal to seek catastrophic illness insurance. The action came at the AMA meeting in Dallas.

Most of the debate about the AMA's Medicredit plan centered around a philosophical question of whether it was better to propose an "acceptable" NHI plan, or if the membership should adopt a stand in opposition to any NHI scheme. Eventually, the House decided to back the tax credits plan, but not without opposition. It was the eighth straight time delegates have endorsed this system which would have tax credits offset the purchase of comprehensive health insurance.

According to backers of the plan, Medicredit would build on the existing system of private health insurance and differs greatly from the plans based on sweeping changes in both health insurance and health care delivery. In contrast to the Kennedy-Corman plan which its own backers admit could cost as much as $118 billion annually, Medicredit would cost only in the neighborhood of $2.5 billion a year and would not demand the many changes called for in the Kennedy bill.

Although the House did endorse Medicredit, and as one AMA official said, "Armed us with a workable alternative," not all delegates supported the idea. John R. Schenken, MD, delegate from Nebraska, said most Nebraska doctors would prefer no NHI plan at all.

Another delegate, Emmit M. Jennings, MD, New Mexico, alikened Medicredit to giving the opposition football team the ball on the 50-yard line "instead of making them fight for every inch." Doctor Jennings said NHI supporters would gladly accept the gift now and work from there to totally control medicine.

Although Medicredit would provide both basic and catastrophic insurance, the California delegation also pushed for separate legislation on catastrophic insurance. Joseph Boyle, MD, an AMA trustee from Los Angeles endorsed the plan for separate AMA legislation, but AMA delegates voted, 104-80, to refer the matter to the Board of Trustees instead. □

AOES Elects New Officers

The Arkansas-Oklahoma Endoscopic Society recently met at Western Hills Lodge in Sequoyah State Park and elected the following officers:

Donald G. Browning, MD, Little Rock, Arkansas, President; Thomas R. Treece, MD, Tulsa, Vice-President; Charles H. Paris, Jr., MD, Fort Smith, Arkansas, Secretary; and, Thomas J. Smith, MD, Little Rock, Arkansas, Treasurer.

Among the new councilors elected were David Jenkins, MD, Tulsa, and Robert Ringrose, MD, Guthrie. □

DEATH
STANLEY K. SHIELDS, MD
1943-1976

A 33-year-old Chickasha physician, Stanley K. Shields, MD, died June 4th, 1976. A native of Bartlesville, Oklahoma, Doctor Shields was graduated from the University of Oklahoma College of Medicine in 1968. Following residency training in cardiology, radiology and internal medicine at Brooke Army Medical Center, San Antonio, Texas, he established his practice in Chickasha. □

Carpenter Resigns As State Health Commissioner


R. LeRoy Carpenter, MD

State Health Commissioner R. LeRoy Carpenter, MD, has announced his resignation to the State Board of Health effective some time during the month of September, 1976. Doctor Carpenter will assume the positions of Research Professor of Human Ecology and Environmental Health and as Director of the newly-created Center for Wastewater Research at the University of Oklahoma Health Sciences Center.

The State Board of Health has appointed Doctor Walter Atkins, Deputy Commissioner for Personal Health Services, State Health Department, to serve as Acting Commissioner of Health.

Joining the State Board of Health in accepting the resignation with regret, Governor David Boren made the following statement, "It is with regret that I have learned that Doctor LeRoy Carpenter has tendered his resignation as Commissioner of Public Health to the State Board of Health. He earlier conveyed his intention to take this action in a personal conversation with me. I am pleased that he is remaining in Oklahoma in the health field. I want to commend him for the fine job he has done during his tenure as Commissioner of Health."

Doctor Carpenter's appointment as Commissioner of Health was February 14th, 1971. He presently serves as Assistant Professor of Research Microbiology and Immunology, College of Medicine, University of Oklahoma Health Sciences Center and since 1974 has been Adjunct Professor of Biostatistics and Epidemiology, College of Health at the OUHSC.

The State Board of Health is actively seeking a replacement for a new Commissioner. Applicants should apply to Otho R. Whiteneck, DDS, President, State Board of Health, P.O. Box 53551, N.E. 10th and Stonewall, Oklahoma City, Oklahoma 73105. □

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Flu Vaccine Program Called Challenge to US Medicine

A successful immunization of the bulk of the American population against swine flu is a challenge to both the public and private sectors to demonstrate that they can combine their energies and efforts in the face of a potentially major health problem, the federal government's top doctor declared recently.

Theodore Cooper, MD, Assistant Secretary for Health of the US Department of Health, Education and Welfare, pointed out in an editorial in the June 21st issue of the *Journal of the American Medical Association* that such a vast immunization program has never been undertaken in this country.

The polio vaccination drives of the mid-1950s and early 1960s were aimed at reaching only children and young adults, Doctor Cooper recalls. Recent flu vaccination programs have been aimed only at certain segments of the population — those in especially high risk categories.

The federal appropriation of $135,000,000 will cover developing, producing and distributing swine influenza vaccine and the scientific and public health measures needed for the program.

"But these efforts and expenditures of public funds will not suffice if they are not supplemented many times over by voluntary action by the medical and other health professions on whom will fall a major responsibility for public education, planning, and direct involvement."

The United States preserves and supports a private health enterprise in the belief that this system of medical care best meets the needs and expectations of the American people, Doctor Cooper said. The federal government is in no position to compel cooperation from anyone, and does not have the resources to carry out a program of this scope entirely on its own.

William R. Barclay, MD, JAMA editor, in another editorial in the same issue called on American physicians to respond to the challenge.

"The American Medical Association urges all physicians to cooperate fully so that the task at hand can be accomplished as quickly and efficiently as possible," Doctor Barclay wrote.

"For most physicians this will be nonremunerative, uninteresting, hard work, but the reward will be very great: the satisfaction of preventing a pandemic and the prevention of thousands of needless deaths." □

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CONTRIBUTIONS

Articles accepted for publication, including manuscripts of annual meeting papers, are the sole property of *The Journal* and must not have been published elsewhere. Authority for approval of all contributions rests with the Editorial Board, and the Board reserves the right to edit any material submitted. Manuscripts should be typewritten, double spaced and submitted in original and one copy. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned on request. *The Journal of the Oklahoma State Medical Association* is not responsible for the statements or opinions of any contributor.

STYLE

Footnotes, bibliographies, and legends for illustrations should be submitted on separate sheets, double-spaced. Bibliographies should follow in order of: name of author, title or article, name of periodical with volume number, page and date of publication. These references should be alphabetized and numbered in sequence.

ILLUSTRATIONS

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NEWS

Members of the Oklahoma State Medical Association, the constituent societies of the association, and all readers in general are invited to supply news items of general interest to the profession.

ADVERTISING

All advertising copy must be approved by the Editorial Board before acceptance for publication. General and miscellaneous advertising rates will be sent on request.

EDITING SERVICE

The Editorial Board reserves the prerogative to submit contributions to a Medical Editing Service when warranted. If such is felt necessary, the Editor will contact the author for approval, informing him that there will be a modest charge for this service.

REPRINTS

Authors will receive reprint order forms from the Transcript Press, P.O. Drawer 1058, Norman, Oklahoma 73069, prior to final publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

BACK ISSUES

Microfilm copies of back issues of *The Journal* may now be purchased from University Microfilms, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The number of physical exams done by doctors in their own offices is likely to double over the next ten years, a market research firm predicted recently. Without help from automation, the firm said, the increase will pose an "unabsorbable workload" on the 200,000 physicians who will then be practicing medicine. The firm, citing a lag in the development of automatic multiphasic health testing, predicted increased use of in-office computerized medical system, supplies, and services.

The AMA's Council on Medical Education reported at the 1976 annual convention that about 60 percent of new medical graduates chose primary care specialties. In 1973, the House of Delegates of the national organization established the policy that at least 50 percent of the graduates should enter residency training in primary care specialties. The AMA has also encouraged the development of family medicine residency programs — since 1970, 270 such programs have been established.

More good news for the AMA! According to a telegram to the Board of Trustees from its Chairman, Raymond T. Holden, MD, AMA dues-paying regular membership totaled 144,107 as of July 9th. The 1976 budget is based on a membership of 144,500. Running totals were given throughout the AMA's annual convention in Dallas, changing almost hourly. State societies which have exceeded their membership figures for the same date in 1975 are **OKLAHOMA,** Alabama, Alaska, Arizona, Florida, Illinois and Virginia.

Good news for both men and women, but even better news for women. According to the National Center for Health Statistics the average life expectancy has risen to 72.4 years (1975). The average life span for a baby girl is 76.4 years compared to 68.5 years for a baby boy. The life expectancy in 1974 was 71.9 years.

The AMA will study efforts by podiatrists to win full staff privileges in hospitals, equal to that of the medical staff. A resolution placed before the AMA House of Delegates was referred for investigation. The resolution urged the Joint Commission on Accreditation of Hospitals not to change its current policies restricting hospital privileges for allied health professionals to the supervision of physicians. A New Jersey delegate reported that the American Podiatry Association is seeking free admitting and discharging privileges for its members.

The AMA has charged that the pending Federal Trade Commission complaint against its ethics code violates the due process provision of the Administrative Procedure Act and is so "nebulous" that a defense cannot be prepared. In a motion filed with an FTC administrative law judge, the AMA asked that the FTC be ordered to specify "precisely which provisions of the **Principles of Medical Ethics** are being challenged, precisely how these provisions operate as a restraint on members (of the AMA) . . . and precisely how any restraints specified violate . . . the Federal Trade Commission Act." The AMA's motion stems from a "Clarification of Issues" in which the FTC said its complaint charges the AMA "with a great deal more than merely imposing 'certain restrictions on advertising'." The FTC clarification statement said the "entire panoply of restrictive agreements contained in the ethics code is under attack." The Administrative Procedure Act, the AMA said, requires an agency to "give a clear statement of the theory on which a case will be tried." the FTC statement does not indicate which facts make certain principles "restrictive agreements," the AMA said, and the statement does not indicate "the theory of law which makes these 'agreements' violations of the FTC Act." □

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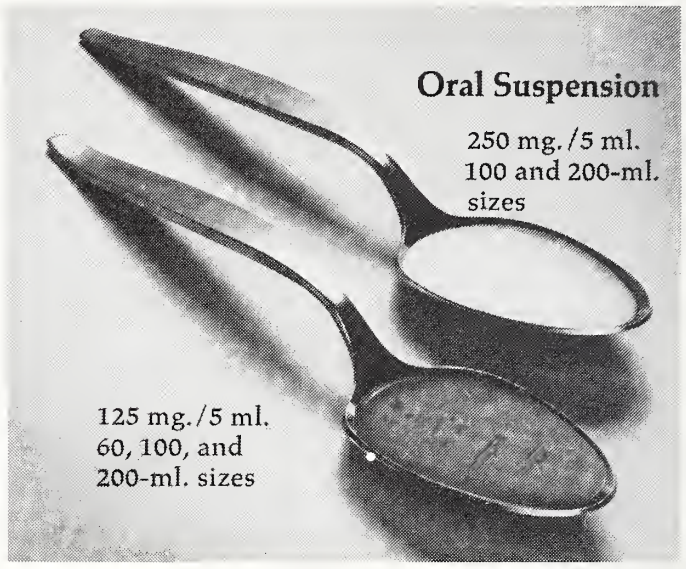
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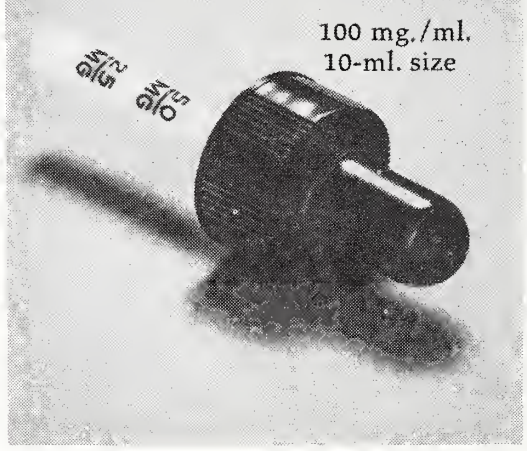


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Eternity or Death

Doctor William S. Middleton's body died a year ago. Compared with the mind and the spirit which it accommodated, the body was inconsequential. Likewise, the death of Dr. Middleton is of no significance compared with the towering significance of his life. His death is worthy of note whereas his life is worthy of praise and emulation. He was a gentleman who inspired gentility, a challenger who created challenges, a physician who perfected physicians.

Dr. Middleton was a teacher of medicine. He taught standing beside the beds of patients, some of whom he cared for; all of whom he cared about.

These few words are not intended to profile the events of a man's life or to cite the titles or offices or awards which he earned. Obituaries serve such purposes, as adequately for Dr. Middleton as for any other mortal. These words are intended to ackowledge the immortal contributions which this teacher of medicine made to mankind.

Endowed with a brilliant mind, Dr. Middleton was a competent scientist but the impact of his teaching the science of medicine — that constantly-changing body of factual knowledge — was dwarfed by the awesome effects of his demonstrations of the art of practicing medicine — that more complex and never-changing body of truths. His wit, his vigor and his bearing helped make him the grand master of clinical histrionics. And his teaching rounds were dramatic masterpieces.

A stern, sometimes harsh disciplinarian, he was a willing and humble servant to his patients. He felt their pain, their loneliness — the desperation of the dying — and made it real for his students. Compassion was born and became a part of every students' personality as Dr. Middleton transformed the intangible qualities of human beings into visible, palpable, measurable realities. He never treated cases. His patients were always people; real people who were his equals, entitled to considerate, dignified and honest treatment. He taught ethics without speaking the word and the roots of his teaching will forever entwine the conscience of every student who knew him. He inspired students to dedicate their minds and their lives to their patients. He honored servitude and wisdom, and endowed them with his life.

Dr. Middleton had a keen perceptiveness about the profession of medicine and those who called themselves doctors. He knew and made his students aware that some merely worked as doctors while others practiced medicine and were physicians. Inevitably, students acquired his talent of discrimination and knew they would be silently shamed if they chose to work in the marketplace.

Today, as our profession is forced into entrepreneurism by destructive political and social influences, and as bedside teachers are replaced with grant-writing, non-practicing, psuedo-researchers, Dr. Middleton's skill and wisdom and integrity — his spirit — must live on. His students must continue his teaching and preserve the values clearly symbolized by his life. His students, who learned so thoroughly how to practice medicine while he looked on must forever teach other students how to be physicians. They must demonstrate, as he did, how to prevent the dissolution of our profession and the transformation of physician to tradesman. Should his students fail this mission, Dr. Middleton will be dead. And glad of it. *MRJ*

president's page



This is the second verse of a familiar song. Summer is over and the kids are back in school; most vacations are at an end and we can now settle down and get a bunch of the work done, which has been postponed, at least to some degree, during the summer doldrums of June, July and August.

For the last three months, the seven OSMA councils have been active and working on their plans to confront the problems the medical profession and our association face. One of the undercurrents I have noticed in the activities of every council and also of their committees is how every problem has at least three viewpoints. One is the viewpoint of the physician related to his desire to provide proper medical care. Another viewpoint is that of government and government bureaus. The third is that of our patients or the consumer.

Since the foundation of the OSMA, the AMA and the entire medical profession is to "do what is best for the patient," the patient's viewpoint is well taken care of. Most patients concur with the medical profession and know that the physician is working primarily in their behalf. The government's viewpoint, including its intervention and bureaucratic regulations, seems to be the primary point of an advisory relationship.

Between now and November 2nd, there will be a great deal of rhetoric and many decisions will be made. Medical practice today is so intertwined with state and federal laws and regulations that the beautiful simplicity of a doctor "just being left alone to practice good medicine" no longer exists. Like it or not we must be involved politically, and now is the time.

I am a democrat. I always have been and probably always will be. I have many friends who are republicans, and many who are independents. I am not talking party politics, I am talking *physician politics*.

In the presidential election the lines are strongly drawn; there is a great difference in the platforms of the two major parties.

One platform calls for comprehensive national health insurance with universal and mandatory coverage. The other party platform states, "The Republican Party opposes compulsory national health insurance . . . we oppose excessive intrusions from Washington in the delivery of health care . . ." In compliance with his party's platform, one of the candidates has stated, "I shall make it the first order of business to introduce a comprehensive program for compulsory national health insurance." Laying all other issues aside and thinking only of the contrast between the two parties and the two candidates on the health issues alone, it is obvious they are diametrically opposite in their attitude and in their philosophy.

Without belaboring the many aspects and the myriad of national health insurance bills that have been introduced during the past twenty years, from the Wagner-Murray-Dingle bill to the Kennedy-Corman bill, it is obvious that we are talking about a distinct change in our present health care delivery system. Undoubtedly, such a change would be far more drastic than all the previous federal legislation concerning health that has occurred in our two hundred years as a nation. The brief outline of the national health insurance system advocated by one party has been estimated by the bureaucrats on the Potomac as costing approximately $93 billion per year. In our experience with governmental health programs, we have found that most of these estimates are usually one-half the actual cost, and the cost in succeeding years escalates in dramatic multiples. National health insurance as a compulsory program would undoubtedly be the most costly expenditure of government and the greatest financial burden on the people of this country ever conceived by Congress. It would dwarf not only defense expenditures, but most of the other costs of running our huge government. When we talk about $93 billion (which would probably escalate into the hundreds of billions of dollars within the next few years), we are not talking about *peanuts*. We are talking about a tremendous burden on our general economy and on all the citizens of the country.

Think carefully about the differences and the choices we must make between now and November 2nd. Not only must every physician vote his considered conviction, but every physician must also rise up and do battle to combat those ideas he feels are dangerous to the people and to medicine as we know it. He must work diligently with his dollars and with his efforts to influence as many people as possible in order to preserve a system which today provides the most comprehensive and efficient medical care in the world.

While we are considering party platforms and presidential candidates, don't forget that there are also many senators and legislators up for election. Choose wisely and well and support strongly those men in Congress who can help preserve the freedom we still have left in the practice of medicine.



OSMA JOURNAL / special

William Osler and the Blockley Dead House

WILLIAM S. MIDDLETON, MD
Madison, Wisconsin

Osler's continued pathological studies while Professor of Clinical Practice at the University of Pennsylvania contributed to the preparation of The Principles and Practice of Medicine (1892).

Sir William Osler would have understood and joined enthusiastically with us in tribute to Mary Dougherty tonight, for he was a man of letters. He would have appreciated Mary's spirit of bookish custodianship and selfless helpfulness. Furthermore had both survived, Henry V. Ogden of revered memory would have afforded an added link.+ The correspondence between these longtime friends was the most extensive encountered by Osler's biographers.

Largely through the remarkable French School of the early nineteenth century the clinico-pathological study of disease inaugurated a new era of medicine. From a theoretical standpoint Bichat (1771-1802) initiated the movement; but Corvisart (1755-1821) was the true founder of the Paris faculty. His pupils included Bayle, Bretonneau, Dupuytren, Laennec and Cuvier. However, Louis (1787-1872) held the preeminent position as the disciple of the bedside-postmortem correlation of disease. His adherence to the numerical method brought a measure of order and definition to medical practice that was to attract scores of young physicians from every country in the civilized world to his clinic in Paris.

The influence of Louis spread early to Dublin, where the famous Irish School of Graves, Stokes, Adams and Corrigan brought renewed life to Anglo-Saxon medicine. Singularly Louis attracted an unusual group of Americans to Paris to partake of the new clinical gospel. For present purposes we are primarily interested in the Philadelphia group. Among the most notable were Meredith Clymer, William Wood Gerhard, Thomas D. Mütter, George W. Norris, Caspar W. Pennock, William Pepper (primus), Alfred Stillé and W. S. W. Ruschenberger. This coterie of young physicians brought Pennsylvania medicine to a pinnacle that left its mark on medical practice for generations.

From the Veterans Administration Hospital, Madison, Wisconsin. Presented before the Milwaukee Academy of Medicine, May 20, 1975.

Doctor Middleton's untimely death occurred on September 9, 1975. He had accepted an invitation to give a Dean's Lecture on History of Medicine at the College of Medicine, University of Oklahoma Health Sciences Center. For his presentation Doctor Middleton planned to use this paper. The sponsors of the History of Medicine Program and officers of the History of Medicine Society are very grateful to Mrs. Middleton and his former secretary, Ms. Betty Schultz, who forwarded us the typescript.

+Mary Dougherty is Assistant Librarian, Milwaukee Academy of Medicine. The late H. V. Ogden, MD, was one of Osler's students at McGill University and later a practicing internist in Milwaukee.

Significantly, utilizing Louis' numerical method, Gerhard for the first time differentiated typhus from typhoid fever. In 1836 a febrile illness occurred in epidemic proportions in Philadelphia. His friend, Caspar Pennock, who had been a fellow student under Louis, and Alfred Stillé as resident physician joined forces in the study of the patients at Blockley. The clinical studies were supplemented by about fifty autopsies (1837), in which the clinching evidence of the distinction between typhus and typhoid fever was thus made, "there was but in one case, and that doubtful in its diagnosis, the slightest deviation from the natural appearance of the glands of Peyer . . . In all other cases the glands of Peyer were remarkably healthy in this disease, as was the surrounding mucous membrane, which was much more free from vascular injection than it is in cases of various diseases not originally affecting the small intestines.

"The mesenteric glands were always found of the normal size, varying, as in health, from the size of a small grain of maize to three or four times these dimensions. With the exception of a slightly livid tint, common to them and the rest of the tissues, they offered nothing peculiar either in consistency or color.

"The spleen was of the normal aspect, in one half the cases, in the other half it was softened, but not enlarged, and in one case out of five or six, enlarged and softened.

"Thus, the triple lesion of the glands of Peyer, mesenteric glands and spleen, constituting the anatomical characteristic of the dothienenteritis or typhoid fever, although sought for with the greatest care, evidently did not exist in the epidemic typhus.

"Although in some respect, the two affections are analogous, and even similar the radical difference of anatomical lesions is at least as well marked as the distinction between the symptoms."

When the Pathological Society of Philadelphia was contemplated (1838), the students of Louis were its prime movers. Gerhard was elected its first president. For the nineteenth and early twentieth centuries a fundamental grasp of pathology was considered the sound foundation for a career in clinical medicine. Indeed until physiologic and physiologic-chemical techniques became tools accessible to the clinician in the twentieth century, pathology remained the keystone of medical education and practice. In the period of transition powerful voices of skepticism were raised. With anachronistic oversight of the manifold contributions of pathology to medical advance, Russell Brain wrote, "Osler frequently emphasized the importance of morbid anatomy, and urged the physician to make a daily visit to the post-mortem room. In his earlier days at least—and we must remember that all his words which I have quoted, were uttered before the discovery of x-rays—there was often no other way of making an accurate diagnosis. But in the post-mortem room we witness the final result of disease, the failure of the body to solve its problems, and there is an obvious limit to what one can learn about normal business transactions from even a daily visit to the bankruptcy court." (**Canad. M.A.J. 83:** 351, 1960.)

Despite this telling analogy, William Osler had built strongly on the foundation of pathology. In the Montreal General Hospital he had performed about 1,000 necropsies, and his participation in the activities of the Medical-Chirurgical Society of Montreal usually dealt with pathology. Incidentally, the movement to Philadelphia was somewhat crowded by his preparation for the Goulstonian Lectures before the Royal College of Physicians, London (February 26, March 3 and 5, 1885) on "Malignant Endocarditis." His transition from Montreal and the adaptation to the Philadelphia scene are matters of record that do not immediately concern the present study. Suffice it to say that Osler found kindred spirits and lifelong friendships that made his short stay in this city most rewarding. The letter to John Welsh Croskey from Osler (Oxford, December 26, 1918) is most illuminating: "I look back with rare pleasure to my term of service at Blockley-1885-89. My appointment I owe to Dr. Pepper. The wards were always full of interesting cases and my literary output, while in Philadelphia, came very largely from the Phila. Hospital service. The malaria experience was of special value. I had the best & kindest of colleagues, Tyson, Bruen, Musser, Hughes and others. With peculiar pleasure, too, I look back on my association with a group of keen & intelligent residents, and with Miss Fisher and Miss Horner in the recently established Training School for Nurses: nor must I forget dear old Owen, on the medical floor, with his Hippocratic gift of prognosis." (Fig 1)

Without minimizing Osler's clinical ac-

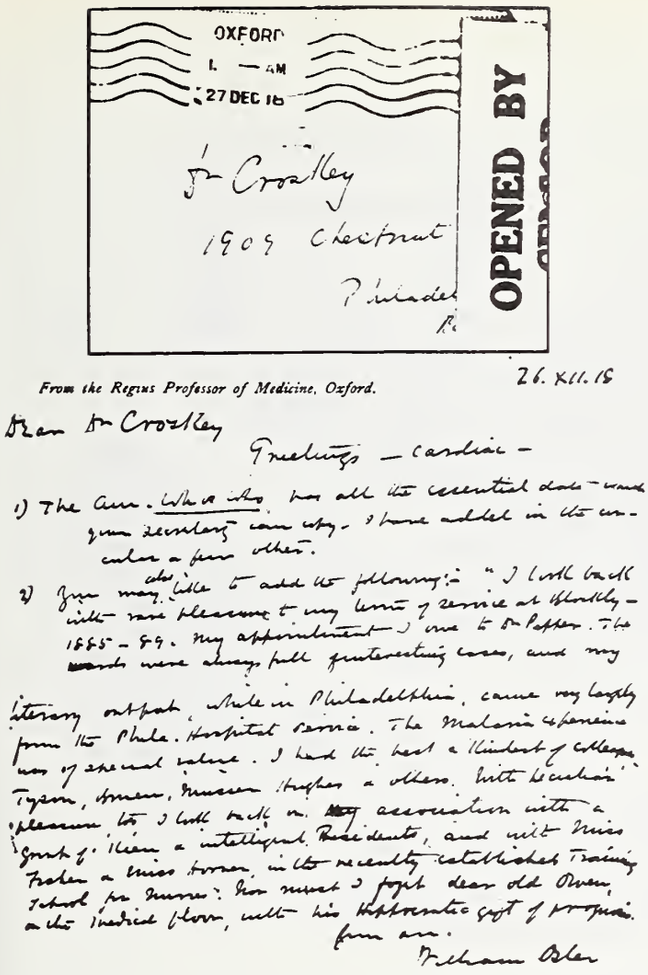


Fig. 1. Letter. "Osler to Croskey" This was quoted in part by Harvey Cushing, *The Life of Sir William Osler*. (Oxford, 1926), Vol. I, P. 290. Figures, 1, 2, 4, 5, and 6 have been previously published in Hunter, Robert J. and others, "Dedication of the Osler Memorial Building of the Philadelphia General Hospital, 'Old Blockley,' June 8th, 1940," *Bulletin History of Medicine* **10:** (June, 1941), 57-95.

tivities at Old Blockley, an unusual opportunity to analyze his prodigious efforts in the Dead House has come to hand.* From the Archives, 91 protocols were available for study. Apparently, since Osler was not the official pathologist to the Hospital, the clearance of the attending physician became a requirement for his performance of this procedure upon patients from other services than his own. Some measure of the scope of his observations may be gathered from the following classification by systems:

Systems		
Central Nervous System		5
Circulatory		18
Cardiac	13	
Vascular	5	
Pulmonary		34
Tuberculosis	23	
Pneumonia	8	
Congestion	1	
Gangrene	1	
Pyopneumothorax	1	
Gastrointestinal		16
Liver	5	
Stomach		
Carcinoma	4	
Gastritis	1	
Pyloric obstruction	1	
Enteritis (tuberculosis)	1	
Colitis	1	
Dysentery	1	
Peritonitis	2	
Renal		7
Nephritis	7	
Miscellaneous	(1)	11
Thyroid	2	
Diabetes mellitus	1	
Delirium tremens	1	
Lead poisoning	1	
Typhoid fever	1	
Erysipelas	4	

The protocols, where complete, afford the date of death and the elapsed time before the postmortem examination. As closely as can be judged by time factors, Osler performed two postmortem examinations a day on seventeen (17) occasions and three a day twice (2). His most frequent associates are listed:

Parke — 5
Jamieson — 8
Talley — 9
Sharpless (brothers) — 12
Bradley — 18

A number of illustrious names, Mills, Musser, Norris, Stahl, Stevens and Tyson, appear as collaborators a single time. Singularly all of them were my teachers at a later date.

A contemporary photograph of an Osler pathological seminar at Blockley (1887) is inelegant by modern standards. (Fig 2.) The only uncovered person was Amelia Gilman. The house officers can be recognized by their visored caps and the brass buttons of their uniform coats. The assisting prosectors, along with Osler, have protective waterproof aprons but rubber gloves had not yet been devised. Two assistants had donned their coats and rolled back their shirt sleeves; but Osler and two other assistants had merely turned their shirt cuffs over their coat sleeves.

From a historical standpoint considerable value may be assigned to the available manuscript notes. A majority are in Osler's handwriting. Naturally they reflect in no small degree his interest of the moment. Yet one may naturally be surprised to encounter such a protocol, as:

*After a number of unproductive approaches through channels, an appeal to Dr. Samuel X. Radbill initiated activity that made available microfilms of a number of manuscript notes of necropsies performed or attended by Osler from the City of Philadelphia Archives.



Osler's Pathological Seminar In The Old Blockley Laboratory, 1887

(From Miss Roberta West's photograph, now in possession of Dr. John Croskey, 1932). From left to right the figures read as follows: 1. Charles Walter; 2. Milo G. Miller; 3. William Beatty Jamison; 4. William Trueman Sharpless; 5. Unknown; 6. C. K. Mills; 7. James Camack Bloomfield; 8. Ambrose McCoy; 9. W. Wanneman; 10. Caspar Sharpless; 11. Sheppard Voorhees; 12. William Osler; 13. Thomas Ashton; 14. James H. McMillan; 15. Augustus A. Eshner; 16. W. Seymond Wilson; 17. Amelia Gilman; 18. Joseph Kahn.

Fig 2 — Necropsy at Old Blockley

34 year old male

Admitted May 25, 1887 and Died June 11, 1887

Attending: Dr. Deaver
Resident: Dr. Jamieson
Postmortem Ordered by: Dr. Deaver
Performed by: Drs. Osler & Jamieson

Clinical Diagnosis—
Cause of Death—Oedema of the Brain

Lesions observed.

"A man moderately well preserved. Nothing peculiar.

Brain — General oedema-opacity of pia-Section of lobes shows nothing special." Case I (See Appendix)

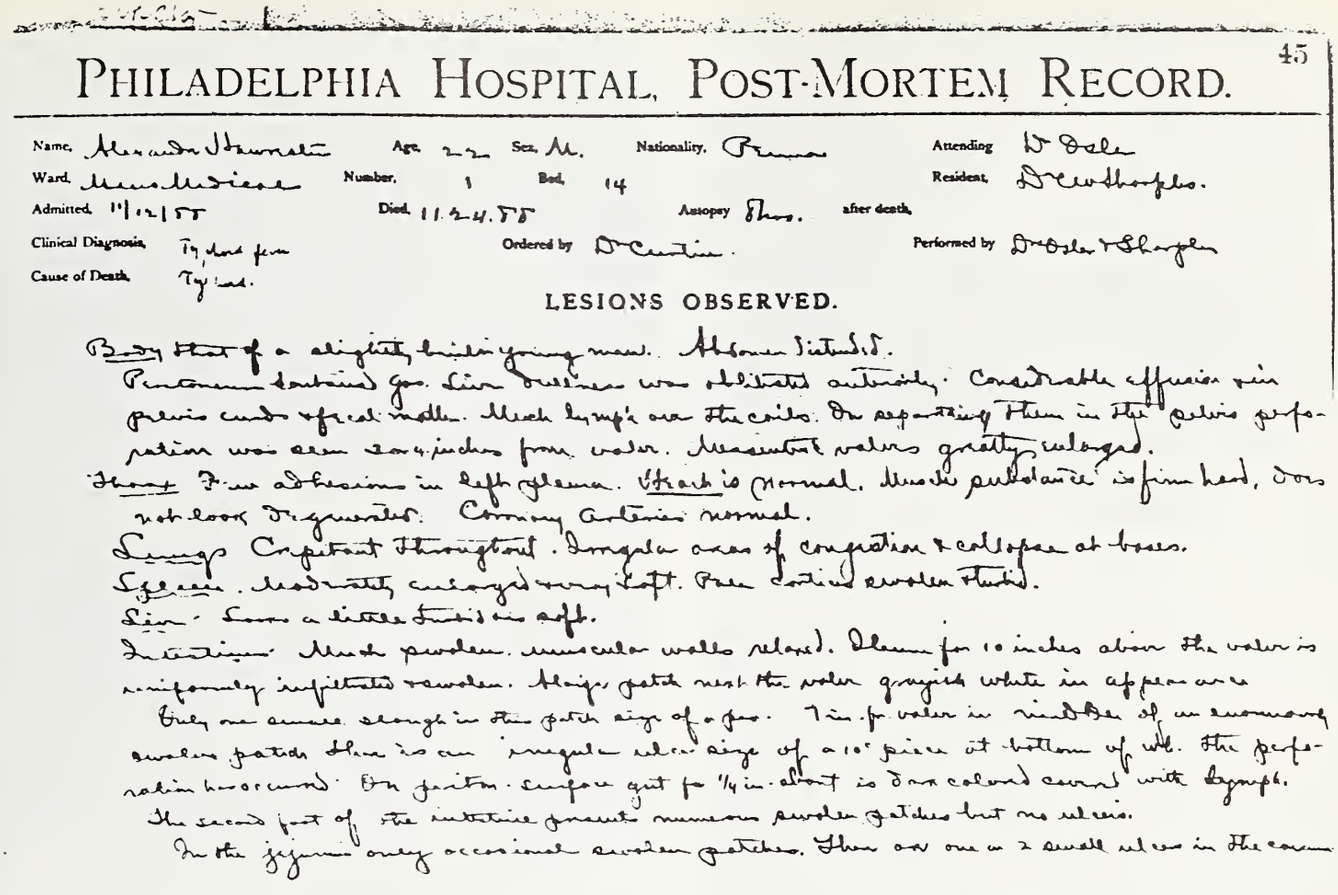
To afford a fair perspective of Osler's observations and the range of his interests, several of the postmortem protocols are analyzed. Appropriately one of the manuscripts describes the gross pathologic findings in a patient dying from intestinal perforation in typhoid fever. The handwriting is apparently that of C. W. Sharpless, Osler's assistant, who regularly misspelled swollen with a single "l."

"Clinical Diagnosis: Typhoid fever.
Cause of Death: Typhoid
Body that of a slightly built young man. Abdomen distended. Peritoneum contained gas. Liver dullness was obliterated anteriorly. Considerable effusion & in pelvis curds & fecal matter. Much lymph over the coils. On separating them in the pelvis perforation was seen 3 or 4 inches from valve. Mesenteric valves greatly enlarged.

Thorax — Few adhesions in left pleura. **Heart** is normal. Muscle substance is firm hard, does not look degenerated. Coronary arteries normal.

Lungs — Crepitant throughout. Irregular areas of congestion & collapse at bases.

Spleen — Moderately enlarged and very soft. Pale cortices swolen & turbid.



PHILADELPHIA HOSPITAL, POST-MORTEM RECORD. 45

Name. Alexander Hamilton Age. 22 Sex. M. Nationality. German Attending Dr Osler
Ward. Medical Number. 1 Bed. 14 Resident. Dr Longfellow.
Admitted. 11/12/55 Died. 11.24.55 Autopsy 8 hrs. after death.
Clinical Diagnosis. Typhoid fever Ordered by Dr Cushing. Performed by Dr Osler & Sharpless
Cause of Death. Typhoid.

LESIONS OBSERVED.

Body that of a slightly built young man. Abdomen distended.
Peritoneum contained gas. Liver dull on percussion was dilated anteriorly. Considerable effusion in pelvis cavity of red fluid. Much lymph over the coils. On separating them in the pelvis perforation was seen 1½ inches from valve. Mesenteric glands greatly enlarged.
Heart. Few adhesions in left pleura. Heart is normal. Muscle pulls under is firm hard, does not look degenerated. Coronary arteries normal.
Lungs. Congestion throughout. Irregular areas of congestion & collapse at bases.
Spleen. Moderately enlarged very soft. Pulp contains swollen stroma.
Liver. Looks a little turbid & is soft.
Intestines. Much swollen, muscular walls relaxed. Ileum for 10 inches above the valve is uniformly infiltrated & swollen. A large patch next the valve grayish white in appearance.
Only one small slough in this patch size of a pea. 7 in. fr. valve in middle of an enormously swollen patch there is an irregular ulcer size of a 10c piece at bottom of wh. the perforation has occured. On periton. surface gut for ¼ in. about is dark colored covered with lymph.
The second floor of the intestine presents numerous swollen particles but no ulcers. In the jejunum only occasional swollen patches. There are one or 2 small ulcers in the caecum.

Fig. 3. Case II. Photograph from *Philadelphia Hospital, Post-Mortem Record.*

Liver — Looks a little turbid & is soft.
Intestines — Much swolen, muscular walls relaxed. Ileum for 10 inches above the valve is uniformly infiltrated & swolen. A large patch next the valve grayish white in appearance.

Only one small slough in this patch size of a pea. 7 in. fr. valve in middle of an enormously swolen patch there is an irregular ulcer size of a 10c piece at bottom of wh. the perforation has occured. On periton. surface gut for ¼ in. about is dark colored covered with lymph.

The second floor of the intestine presents numerous swolen particles but no ulcers. In the jejunum only occasional swolen patches. There are one or 2 small ulcers in the caecum." Case II. (Fig 3)

A classical example of high grade aortic stenosis is described in the body of Frederick Brecht. Again C. W. Sharpless, the assistant, wrote the necropsy notes of Osler's observations. The cardiac findings are singularly graphic: "On the wall just above the post. segment of mitral there is a prominent ridge firm & hard, which represents the cartilaginous & calcified aortic ring. . . . Aortic orifice is represented by a linear slit about 1 inch in length & from an ⅛ to ¼ inch in breadth. Edges are formed by enormously thickened & calcified aortic segments. Two of these valve segments seem to have fused. . . . The sinuses of Valsalva look greatly distended forming large pockets behind the valves." Case III (See Appendix)

The incidence of tuberculosis was especially high in the Blockley population of the Osler period. The following necropsy of a tuberculous patient is characteristic. Osler wrote the findings in the central nervous system and Sharpless, the remainder. Osler described extensive thrombosis of the cerebral veins and sinuses, "Covering the entire inner surface of the dura over hemispheres is a thin sheeting of grayish white appearance & in places distinctly hemorrhagic (Pachymeningitis)." In no detail were characteristic tubercles described. However in the lung characteristic tubercles, infiltration, excavation and fibrosis were noted. A sago spleen of amyloid degeneration was found. (Case IV, See Appendix)

From the heading of another protocol (R.R.) Walker was the attending physician and Seymour, the resident. The necropsy was ordered and performed by Osler. The clinical diagnosis was cerebral syphilis. Upon opening the calvarium upward displacement of the pons was encountered. The medulla especially on the left side was greatly enlarged. The cerebellum, pons and medulla were separated from

the crura and removed after sectioning the cord. A large mass destroyed the symmetry of the medulla. No trace of the restiform bodies or the posterior pyramids was seen. The section of the medullary mass disclosed a gelatinous infiltrative tissue. The overlying cerebellum was thinned by compression. (Case V, See Appendix)

The change of the clinical diagnosis of cerebral syphilis to tumor of the medulla affords another example of Osler's eagerness to profit by the disclosures of the necropsy. William T. Sharpless, a resident of that period, related that "If I found something especially interesting he would send out a runner to get all the boys and show what a wonderful thing he had found and how interesting and instructive it was. Once in a ward class there was a big colored man whom he demonstrated as showing all the classical symptoms of croupous pneumonia. The man came to autopsy later. He had no pneumonia, but a chest full of fluid. Dr. Osler seemed delighted, sent especially for all those in his ward classes, showed them what a mistake he had made, how it might have been avoided and how careful they should be not to repeat it."

Osler might well have taken a page from Thomas Bond's Introductory Lecture at Pennsylvania Hospital, December 3, 1766: "And if the Disease baffles the power of Art, and the Patient falls a Sacrifice to it, he then brings his knowledge to the Test, & fixes Honour or discredit on his Reputation by exposing all the morbid parts to View, and Demonstrates by what means it produced Death; and if perchance he finds something non-suspected, which betrays an Error in Judgment, he like a great & good Man, immediately acknowledges the mistake, and for the benefit of survivors, points out other methods by which it might have been more happily Treated: —The latter part of this Field of Tuition is the surest method of obtaining just Ideas of Diseases."

Perhaps no better example of Osler's attention to detail and to pathologic sequences can be cited than the patient with melanosarcoma. Originating in the retina, penetration of the sclera was followed by metastases to the brain, pleura, heart (myocardium, pericardium and endocardium), gastrointestinal tract, kidneys, pancreas and liver. The liver weighed 17¾ pounds (8067 grams) and grossly was uniformly dark. On section the irregular pigmented areas occupied a greater portion of the cut surface. (Case VI, See Appendix)



Fig 4 — Post (Dead) House — Blockley

Epilogue

In 1885-6 the new Pathological Building was constructed at Old Blockley. (Fig 4) By a singular coincidence this date marked William Osler's arrival in Philadelphia. Social and professional recognition were his from the outset of his transplantation. Here he found his bride and here were established lasting friendships. Among the latter none was more intimate and understanding than that with S. Weir Mitchell, whose delightful poem expresses their close relationship:

"Show me his friends and I the man shall know;
This wiser turn a larger wisdom lends:
Show me the books he loves and I shall know
The man far better than through mortal friends.

Do you perchance recall when first we met—
And gaily winged with thought the flying night
And won with ease the friendship of the mind,
I like to call it Friendship at first sight.

And then you found with us a second home,
And, in the practice of life's happiest art,
You little guessed how readily you won
The added friendship of the open heart.

And now a score of years has fled away
In noble service of life's highest ends,
And my glad capture of a London night
Disputes with me a continent of friends."

*"Books and the Man," Proc. of the Charaka Club, 11, New York.

Service on the wards of the Philadelphia General Hospital as well as the Hospital of the

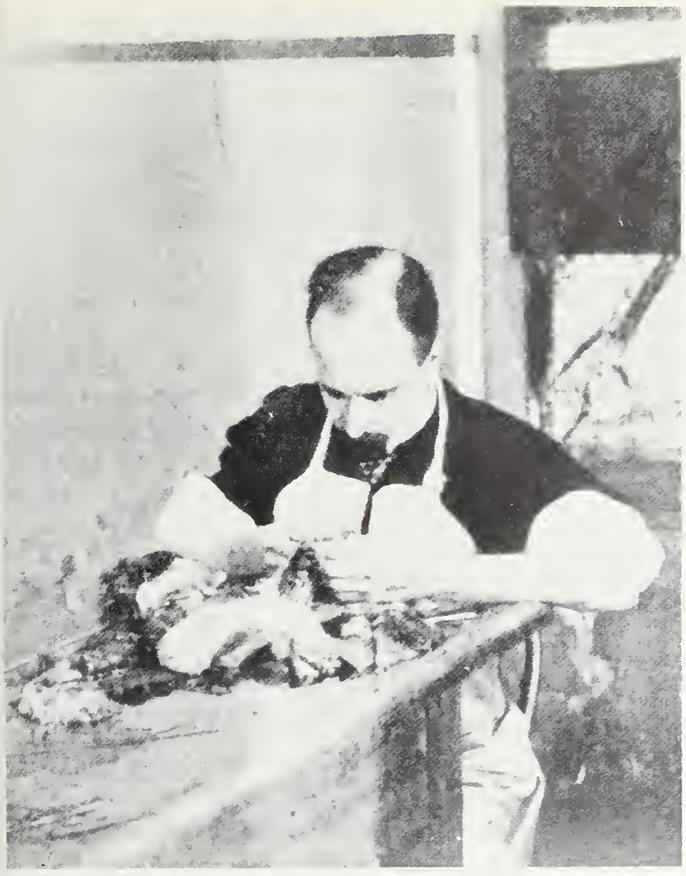


Fig 5 — Osler at Necropsy Table

University of Pennsylvania had been arranged for Osler by Professor William Pepper. However, Osler's insistence upon the clinicopathological study of disease processes led to an unusual division of time between the two interfaces. As we have seen, even for the period involved (1885-9), he spent a great deal of time at the necropsy table. (Fig 5) The influence of this experience in Montreal and Philadelphia upon his clinical approach and writing was profound, if immeasurable. From the evidence herein adduced, it can be assumed that the time, energy and thought expended by Osler in the Dead (or Post) House, as the Pathological Building came to be known, were most rewarding. Undoubtedly such experiences were reflected in his classical textbook on medicine, the first edition of which was published only three years after he left Philadelphia. (1892)

With the construction of a new building for pathology, the Dead House fell into disuse. At a gathering of former Blockley residents and friends, Kenneth M. Lynch, an ex-resident in pathology, suggested that the building be rehabilitated in honor of William Osler. The movement thus initiated found favor and material support came from John Wyeth & Brother, Inc. The postmortem table, at which he had worked, and his instruments were preserved. On June 9, 1940 the dedicatory ceremony of the Osler Memorial Building was observed before a distinguished company.



Fig 6 — "Osler at Old Blockley"

Perhaps most impressive on this occasion was the unveiling of the painting, "Osler at Old Blockley," by Dean Cornwell. (Fig 6). While the setting in the tree shaded yard of Blockley with the Dead House in the background is rather idyllic, the artist has caught the spirit of the central figure — Osler, the teacher at the bedside of a patient with the resident physicians and an attendant nurse about him.

The historical sequence was broken by the demands of progress. The Osler Memorial Building was razed in 1970 to make way for Children's Hospital.

APPENDIX

Dr. Middleton originally selected six postmortem records for reproduction and comment. In the manuscript he included the transcription of Case II, of which the photograph is published. Since reproductions of the others would not be legible, R. Palmer Howard, MD, transcribed a brief additional note for Case I, and the full texts of Cases III-VI. The transcriber compared the handwriting of the records with that in the letter to Dr. Croskey and other examples of Osler's hand. Several scribes recorded the manuscripts in Cases I-VI, of which the one for Case II seems unique. The writing for the identification and the upper part of "lesions observed" in Case IV differs from that of the lower part and the word "phthisis" for the cause of death. Since the latter resembles all the writing in Case III it may be that of Dr. T. Sharpless. In Case V the writ-

ing of "Tumor of medulla" for cause of death in the top paragraph, and of all the final line of the report resembles Osler's penmanship. In Case VI the writing of the main report is distinguishable from several insertions in the identification information, but the words "Dr. James Tyson" and "Dr. Osler" following "ordered by," and "performed by," respectively, resemble Osler's writing. Such words are marked by asterisks.

All the records were on pages printed with the heading "PHILADELPHIA HOSPITAL, POST-MORTEM RECORD.", and with printing of the words "Name", "Age", . . . "Cause of Death", and "LESIONS OBSERVED". The printed words are in bold face type in the transcriptions.

Case I. Addition.

Following the description of the brain, the record is blank except for this notation at the bottom: "Aortic valves, one segment anterior two posterior, right posterior is more a lateral valve — posterior coronary behind left posterior valve, right coronary given off anterior segment."

Case III

Name, Frederick Brecht **Age,** 53 **Sex,** Male **Nationality,** German
Attending Dr. Osler
Ward, Men's Med. **Number,** 1, **Bed,** 9 **Resident,** C. W. Sharples
Admitted, 11-24-1888 **Died,** 1-8-1889 **Autopsy** 23½ hours **after death, Clinical Diagnosis,** Valvular heart disease **Ordered by** Dr. Osler
Performed by Dr. Osler & Dr. T. Sharpless
Cause of Death, Aortic valve disease. Asystole

LESIONS OBSERVED.

Mod. nourished man, fairly muscular, brown cicatrices on skin, face not specially pale. Rigor mortis present & well marked. In abdomen — position of viscera normal. Lacteals full. Liver projects a hand's breadth beyond costal margin & is rough & cirrhotic.
Thorax. No adhesions. Pericardium smooth. Heart large. Chief part of front of heart formed by right chamber. Moderate amount of clots in right chambers. Left ventricle still in rigor mortis. In the left ventricle only one very small clot. Left auricle contains a good deal of blood & coagulum. Heart weighs 21 oz. Rgt. auricle is large. Tricuspid orifice is large & admits 4 fingers. Valves are thin & look normal. Rgt. ventricle moderately dilated, walls rather thick. Pulmonary valves are opaque & thick at point of attachment. Left auricle large, walls a little thickened & endocardium opaque. On the wall just above the post. segment of mitral there is a prominent ridge firm & hard, which represents the cartilaginous & calcified aortic ring. Left ventricle hypertrophied looks globular, projects into the rgt. cavity, wall measure ¾ inch in septum [?]. Mitral valve thin & not at all thickened at edges. Cordae tendinae normal. Mitral orifice admits 3 fingers at second joint. Base of ant. segment presents several spots of calcification. Aortic orifice is represented by a linear slit, about 1 inch in length & from an ⅛ to ¼ inch in breadth. Edges are formed by enormously thickend & calcified aortic segments. Two of these valve segments seem to have fused close [?], behind which the post. coronary arteries pass off. No fresh vegetations. Orifices of coronaries are free. Sinuses of Valsalva look greatly distended forming large pockets behind the valves. The ant. coronary artery divides into two main branches, one of which passes down the septum in usual position & presents in its course in [?] intima flakes of atheroma. The other main branch passes through beneath the superficial layer of muscular substance directly down the ant.-lateral wall of ventricle.
Lungs extremely emphysematous. Much carbonized patches of fibroid thickening.
Spleen. Large & soft.
Stomach. Extensive post-mortem solution at the fundus and does not extend beyond the mucous coat.
Pancreas normal. Bile flows from the papilla.
Liver is of moderate size. Surface is rough particularly the under surface of dark color contains much blood [,] indurated firm & medium grade of alcoholic cirrhosis.
Kidneys are large beefy looking contain good deal of blood a few cysts.

Case IV

Name, Bernard McIntyre **Age,** 33 **Sex,** . . . **Nationality,** . . . **Attending,** . . . **Ward,** Men's Medical **Number,** 7 **Bed,** 28 **Resident,** C. W. Sharples
Admitted, Oct. 20, 1888 **Died,** Jan. 2, 1889

Autopsy 6 hrs **after death**
Clinical Diagnosis, Phthisis **Ordered by** . . . **Performed by** Dr. Osler & Sharpless
Cause of Death, Phthisis

LESIONS OBSERVED.

Brain. The dura on either side of longitudinal fissure looks more congested than normal & veins about pacchionian bodies show plainly. Slitting open longitudinal [sinus] find that it is filled with thrombus closely adherent to walls & at places quite fibrinous & grayish yellow in color, but for most part reddish black. Lower part of sinus very full & firm [.] Thrombus extends into L. lateral sinus which is occupied in entire extend [t] to firm coagulum. Torcular herophili almost completely occupied by thrombus. Straight sinus is free. Larger cortical veins all full of dark & in places grayish white thrombi. Where veins enter longitudinal sinus there is great deal of firm gelatinous oedema. On removal of dura, veins attached, most prominent & thickened mass of clot is about center of longitudinal sinus. Good deal of thickening of pia & adhesions of pia to arachnoid & slight brownish pigmentation. Membranes at base appear normal. Both optic nerves are gray & atrophic. Both tracts small & gray. Veins in ventricular wall distended.

Covering the entire inner surface of the dura over hemispheres is a thin sheeting of grayish white appearance & in places distinctly haemorrhagic (Pachymeningitis).

Heart shows no special changes, valves are normal.

Lungs Left, cavities at apex, many fibroid thickened masses in both upper & lower lobes. Lower lobe, a few scattered tubercles. Rgt. lung, large irregular cavity occupies greater part of upper lobe, much irregular fibrous tissue about it. Bronchial tubes all much dilated. Middle lobe but little affected. Bronchial glands enlarged pigmented contain tubercles.

Spleen enlarged typical amyloid change. Sago spleen,

Kidneys are of average size, weigh — oz. Capsule attached. Surface rough, large coarse granules. Vessels are stiff [,] cortex pale great increase in fibrous tissue. Supra-renals very hard & firm.

Intestines show no tubercles.

Case V

Name, Robert Penton **Age,** 36 **Sex,** Male **Nationality,** Negro
Attending, Dr. Walker
Ward, Men's Med. **Number,** 6 **Bed,** 6 **Resident,** Seymour
Admitted, 3-4-87 **Died,** 3-10-87 **Autopsy** 24 hrs. **after death.**
Clinical Diagnosis, Cerebral-Syphilis **Ordered by** Dr. Osler
Performed by Dr. Osler
Cause of Death, Tumor of Medulla.*

LESIONS OBSERVED.

Body medium sized, well nourished. Skin shows old scars on forehead, arms & few on thorax. External parts of skull normal. It is of medium thickness, rather thicker than normal in frontal & thin in the temporal regions. A good deal of blood escaped on the removal of skull-cap. The medulla was cut at junction with cord. Part about base in the following conditions. The olfactory & optic nerves small. No effusion in the interpeduncular space, but the pons [?] is pushed up & its anterior border is very close to the commissure. Vessels of the circle of Willis contain blood & look natural. Pons symmetrical not swollen. 3rd, 4th, 5th & 6th nerves look natural. Medulla enormously swollen, particularly on the left side. Arachnoid over it is clear. Vertebral arteries grooved to the surface. Condition of nerves superficially is as follows: Hypoglossal filaments very distinct on both sides; on **right** side the Glossopharyngeal, Pneumogastric & Accessory look normal, on the **left** side [space approximating 10 words is blank.] Posteriorly the arachnoid is clear & a very large convoluted vein appears at back part of medulla & extends into 4th ventricle. The crura were cut through & Cerebellum, Pons & Medulla removed together. (**Note**) Dura-mater very adherent, the longitudinal sinus & veins entering in it very full. The sinus is unusually large & on either side of it & covering it on its entire side there is a line of Pachymeningitis. The lateral & 3rd ventricles contain slight excess of fluid, walls are smooth. Vessels over the convolutions are somewhat dilated & full. External examination [of] the gray matter looks natural, in one or two places it is congested. Section of the hemispheres shows them to be normal. Slight oedema & infiltration of white matter. Gray matter shows spots of congestion. No fosci [sic] of disease. 4th Ventricle is dilated particularly in the lateral recesses. The fallopian aqueduct not enlarged. Floor of ventricle above level of acoustic striae looks natural. The right acoustic striae not so

distinct as the **left.** The large vein reaches as high as the level of the striae at their circle over the lower part of medulla. The lower part of **medulla** is occupied by **large mass,** which completely destroys symmetry & extends from **Calamus** to Cord. The pia-mater covers this growth everywhere. On the left side a reddish-brown color, on the right side it is covered by the white matter of the medulla. No trace to be seen of the Restiform bodies or of the post. pyramids. The large vein seems to emerge from posterior part of the **Tumor.** The entire surface of the medulla is much swollen. Right **olivary** & left one are visible, but wider apart than natural. In removal the section cut through a gelatinous infiltrated tissue. Parts of skull about base normal, unusual adhesion of dura to bone around foramen magnum. Cerebellum a little compression & thinning of the part above the tumor; no other changes. Cervical portion of cord swollen & soft. On section the central canal is somewhat dilated. For 1½ inch of cervical cord, gray & white substance soft & postero-lateral columns have a very grayish tint. In dorsal part of the cord, the gray matter is in places congested.

Heart. Average size. Left ventricle a little thick. Pulmonary & Tricuspid valves normal. Aortic segments distinctly opaque. Mitral orifice narrow. Edges thickened particularly where chordae tendinae are attached posteriorly. Anterior chordae tendinae not so involved. Auricular edges of valves covered with a series of fresh endocardial vegetations. Some of these have blood clot adherent, others are smooth. Aorta small & a few patches of atheroma.

Lungs. Crepitant except at bases which are deeply congested; bronchi filled with mucus. One or two small nodular bodies scattered through lower lobes.

Kidneys. Small, capsule adherent, & few cysts. Surface distinctly granular, not much chromation [?] of cortex.

Spleen. Not enlarged, pulp soft.

Liver. Average size, surface smooth, substance natural looking. Stomach & Intestines no special changes.

Cause of death. Tumor of Medulla. Glioma.*

Case VI

Name, Thomas Holland **Age,** 73 **Sex,** Male **Nationality,** . . . **Attending** Tyson
Ward, Men's Medical **Number,** 7 **Bed,** 12 **Resident,** Diller
Admitted, 11-7-84 **Died,** 3-13-87 **Autopsy** 28 hrs **after death.**
Clinical Diagnosis, Cancer of Liver **Ordered by** Dr. James Tyson*
Performed by Dr. Osler*
Cause of Death, Melanotic sarcoma of liver

LESIONS OBSERVED.

Body that of a medium-sized elderly man. Skin deeply jaundiced. Legs, thighs & back oedematous. Over skin of thorax 5 or 6 pigmented bodies varying in size from a pin-head to a large pea.

Abdomen.

Intestines distended, small amount of bloody exudation. Liver projects 5-6 inches below costal margin. Left lobe in nipple-line at least 4 inches below costal margin. Surface of liver uniformly dark in color. Diaphragm corresp[onds] on left side to fifth rib & on right side to fourth.

Thorax.

In right pleural cavity an effusion of bloody fluid. On left side a few ounces of same.

Pericardium.

Beneath visceral layer a number of small dark bodies varying in size.

Heart.

Chambers contain fluid blood & clots. Valves on right side normal. Endocardium bile stained. Edges of tricuspid thickened. Beneath endocardium of right ventricle numerous small miliary bodies some pale, most of them dark in color. On left side mitral valves thickened, aortic a little opaque, beneath the endocardium numerous larger secondary masses. Throughout substance many nodular growths, some larger than peas.

Lungs.

Left crepitant, oedematous, congested posteriorly, no secondary nodules.
Right collapsed. Flakes of lymph cover surface. No cancerous nodules. A few pigmented nodules on costal pleura.

Stomach.

Distended, mucous membrane soft. A few pigmented spots scattered through mucous membrane.

Duodenum. Contains much mucus. The papilla is swollen. Pressure on the duct causes a clear fluid to flow, no obstruction. Gallbladder almost empty. Numerous pigmented masses throughout it. Hepatic artery large.

Portal vein free, admits little finger readily.

Pancreas. Presents numerous secondary nodules, some as big as beans.

Spleen. Mostly adherent to diaphragm. Secondary mass as large as a small walnut in one end.

Kidneys. Left. Many small pigmented bodies in fatty capsule. Organ tough, arteries [?] thick, a few cysts through substance. Here & there some small pigmented bodies. In **right kidney** there are larger secondary nodules, some as large as marbles.

Retro peritoneal glands. Not enlarged & not melanotic.

Aorta. Numerous flakes of atheroma.

Right supera-renal capsule removed with the liver. Both of the capsules are normal.

Liver. Shape of organ retained. Right lobe larger in proportion than left. Surface is smooth. Capsule thickened in places. Numerous small superficial indentations. Color is uniformly dark, here & there having yellow spots. There are some button-like projections which are surrounded by distinct depressions. These prominences are extremely hard. Section through substance shows it to be tough. The surface shows [:] 1st Large irregular deeply pigmented areas, which occupy the greater portion of the surface; some of these are intensely black [;] other areas are mottled with grayish white: 2nd Irregular areas of liver substance, greenish yellow, with black specks scattered through them [;] upper & back portion of right lobe and in left lobe are considerable areas of liver substance. Liver weighs 17¾ pounds. [8067 grams]

Brain. In right frontal area of skull-cap two pigmented areas in diploe.

Dura. Several small pigmented masses adhering to under surface of dura. One of them size of pea compresses the angular convolution. At the base of skull in anterior & middle fossae are from 10-12 small pigmented bodies. In the left fossae small but well marked haemorrhagic pachymeningitis.

Arteries at base of brain atheromatous. Section of brain, no secondary masses in substance.

Eye Right.

Lower part of conjunctiva shows a pigmented mass. This passes backwards & reaches as far as entrance of optic nerve. It is lobulated, & looks as if it had perforated sclerotic. Old cataract, with anterior synechia & obliteration of pupil. On section of eye, the whole ball behind the lens is occupied by a pigmented mass, which is intensely black except at one spot. It has perforated the sclerotic at one point, and grown out beneath the conjunctiva. □

ANNOUNCEMENT

Application for Research Grants-in-Aid and for Postdoctoral Research Fellowships, for the year beginning July 1st, 1977, are now being accepted by the American Heart Association, Oklahoma Affiliate for review by the Research Policy Committee.

Application forms may be obtained from the American Heart Association, Oklahoma Affiliate, Inc., 800 N.E. 15th Street, P.O. Box 11376, Oklahoma City, Oklahoma 73111. These applications must be received or postmarked no later than **November 1st, 1976.**

OSMA JOURNAL / scientific

Cardiac Rehabilitation In A Community Hospital

NANCY MOZINGO, RN
JOSE R. MEDINA, MD, FACP, FACC

Cardiac rehabilitation should be an integrated part in the treatment of patients with coronary disease. To avoid the detrimental effects of bedrest, a cardiac rehabilitation program should be instituted early in the treatment of patients with myocardial infarction. A supervised program in a community hospital is presented.

Recent studies have emphasized the need of early ambulation for patients with an uncomplicated myocardial infarction. To avoid the deconditioning effects of bedrest and to promote a positive, hopeful, yet realistic emotional outlook, a program of cardiac rehabilitation should be instituted.

The advantages of early mobilization in view of the detrimental effects of bedrest are obvious. Bedrest can cause a decrease in physical work capacity, an increase in heart rate response to effort, a decrease in adaptability to change in posture primarily manifested as orthostatic hypotension, and a decrease in the contractile strength of the body musculature.[1]

It is also recognized that the psychological stresses of a patient with myocardial infarction are significant.[2] Depressive reactions due to the threat of sudden death, the inactivity and job uncertainty, deprivations, and restrictions imposed (giving up cigarettes, reducing eating, and avoiding excitement), and the possible changes in interpersonal relationships (marriage, sexual, etc) are frequent and make the convalescence of the patient with myocardial infarction rather difficult.

The cardiac rehabilitation program at Hillcrest Medical Center in Tulsa was developed with the premise that patients with symptomatic arteriosclerotic heart disease (angina, myocardial infarction) can, and should return to normal living.

The program includes gradually increasing physical activity, counseling, and education, begun in the hospital from the first days of hospitalization and continuing after discharge, as a program of more vigorous physical activity. Thus, the patient is encouraged to look forward to activity, not inactivity.

The goals of a successful rehabilitation program for patients after myocardial infarction include:

1. Return to gainful employment or independent living.

2. Reduction of the economic burdens of myocardial infarction on the patient, his family, and his community through a shortened hospital stay, a decreased need for convalescent care, and an increased and more rapid return to work.

Presented at the Annual Joint Meeting of the American College of Physicians Oklahoma Region and Oklahoma Society of Internal Medicine, October 10, 1975.

3. Reduction of the risk of recurrent myocardial infarction, premature death, or complications of myocardial infarction, ie, implementation of a secondary prevention program.

4. Improvement in the quality of life.

The program is instituted in the ICCU,[3] when the patient's condition is relatively stable, usually within twenty-four hours after acute myocardial infarction. Contraindication to this include severe heart failure, shock, intractable pain, or uncontrolled arrhythmias. Within the first four-to-five days of acute illness, the aerobic power of the majority of Class I-II patients is sufficient to allow them to sit in a bedside chair and take care of their ordinary needs. Those activities require only 1-1½ METS. (A MET is defined as the basal metabolic requirement at rest.)[1] Passive range of motion exercises of all joints require only one MET and can be started early.

In the uncomplicated cases, a gradual increase in activities which have low energy requirements (in the range of 1-2 METS) is instituted. This includes self-care, feeding, shaving, bathroom privileges with help, and active body movements of upper and lower extremities approximately two to three minutes during each waking hour for the second and third days. This also includes dangling and sitting in a chair.

For the more complicated cases, passive body movements of the upper and lower extremities can be recommended. Isometric exercises should be avoided in all cases, because of the disproportionate effect on the heart and blood pressure.

All activities and exercises are closely monitored by nursing personnel, so the response of the patient can be evaluated objectively. An activity is considered to be excessive if there is an increase in heart rate above 120 BPM, changes in B/P of 20-30 mm Hg above that at rest, chest pain, dyspnea, or increased ST-T displacement.

As the patient progresses from the intensive coronary unit of the cardiac recovery unit, education to the patient and his family becomes more important. Understanding the disease and the goals of the rehabilitation and prevention program permits them to assume a more involved role in such endeavors.

As the patient progresses and more activity is allowed, he is encouraged to have his meals in the station dining room. This provides an excellent opportunity for the dietician to teach the patients about the proper diet and its preparation.

The occupational therapy department is also involved in the program. They offer the patient advice and assistance in performing activities of interest to him, which stays within the limits of energy expenditure for each individual patient.

Reinforcement and repetition is the key to successful patient and family education. The components of patient and family education that are covered by nurses are:

1. Nutrition — The dietician helps the spouse plan for the proper diet—hints on purchasing and preparing food for the patient at home.

2. Physical Activity — The major objectives of physical activity during this stage are to continue to prevent the harmful effects of prolonged bedrest and to increase cardiovascular functional capacity to a level that will allow reasonable self-care after discharge.

3. Sexual Activity — This should be discussed with the patient and spouse. It is generally recommended that resumption of sexual activity parallel resumption of other usual activities.

4. Cessation of Smoking — It is a proven fact that there is an association between cigarette smoking and coronary artery disease. There are three times as many coronaries in cigarette smoking males, when compared to a group of non-smokers. The patient must be motivated to correct this risk factor.

5. Myocardial Infarction — Discuss the character of the illness as it relates to immediate and long-term plans for management. The patient should have a realistic expectation of his future pattern of living and his requirements for health care.

Nancy Mozingo, RN, was graduated from the Sparks Memorial Hospital School of Nursing in 1961. She is a Past-President of the American Association of Critical Care Nurses and a member of the American Heart Association.

Jose R. Medina, MD, FACP, FACC, was a 1961 graduate of Central University, Quito, Ecuador. Doctor Medina is an Assistant Professor of Medicine at the University of Oklahoma Health Sciences Center. He is a Fellow of the American College of Physicians and the American College of Cardiology. Other memberships include the American Heart Association and the American Thoracic Society.

6. Control of Associated Diseases — Particularly hypertension and diabetes mellitus and other coronary risk factors.

7. New or Recurrent Symptoms — Particularly chest pain: Intensive education of the patient to seek immediate medical care is mandatory to decrease early deaths from recurrent myocardial infarction.

8. Medications — Information about actual medications prescribed including their names, dosage, desired effects, and possible adverse effects.

The in-patient program was financed through appropriations in the budget of the Progressive Cardiac Unit. There is no charge to the patient for participating in the program. From January 1, 1975 to June 30, 1975, there were forty-five patients with acute myocardial infarction participating in the program. The average hospitalization was fourteen days.

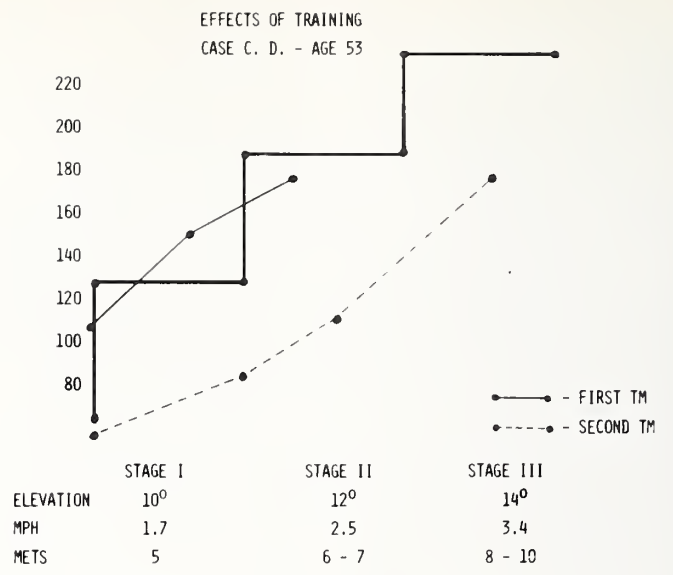
As the patient progresses from the hospital phase to the home phase, more emphasis is placed on the physical reconditioning. The rehabilitation program is prescribed and coordinated by the personal physician. This includes drugs, diet, and exercise therapy. After a complete medical examination is done by the private physician, an exercise evaluation or stress test is done to determine the degree of disability and exercise tolerance.

From the results of this stress test, an exercise prescription is written giving a target heart rate, which the individual should reach when exercising.

Once the functional capability has been determined, the patient is enrolled in the program to exercise on ergometers and the treadmill for three visits per week for the first quarter. After a second stress test, the patient exercises twice a week for the second quarter; once a week for the third quarter; and once every other week for the final quarter. A final stress test is performed to ascertain the results.

As the patient progresses in the program, he is gradually started on exercises and a walking program to be done at home. As the number of visits to the rehabilitation program decrease, more emphasis is placed on the home program.

For example, if the patient is working on step 9 on the treadmill, which is a ten per cent grade elevation at 1.7 mph or the MET equivalent of 5 METS and not developing any symptoms of electrocardiographic changes, he can

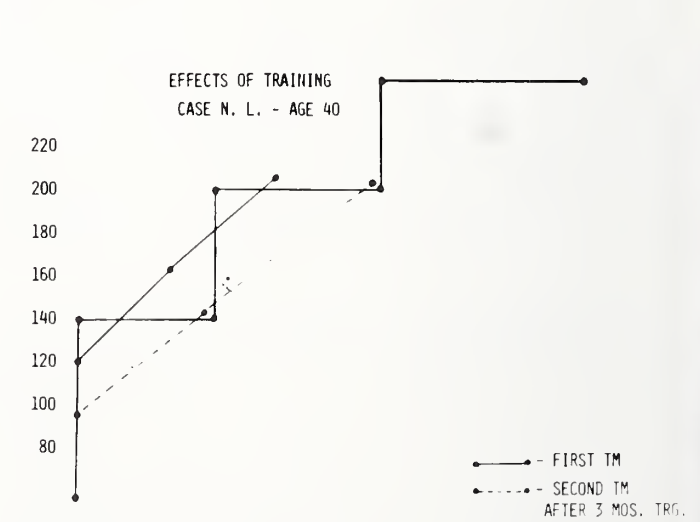


Graph 1 shows the effects on double product of three months training in a 53-year-old male who had experienced a myocardial infarction.

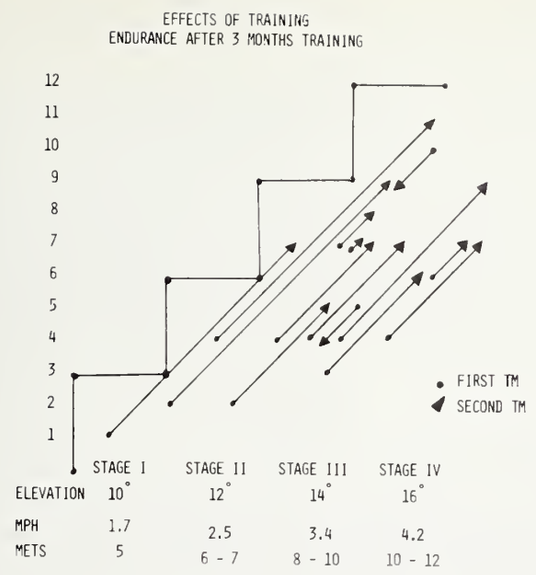
safely handle any activity which requires 5 or less METS.

Systematic active rehabilitation programs have been shown to enhance the functional capacity of cardiac patients.[5] After training, the patient's response to the same workload is characterized by:

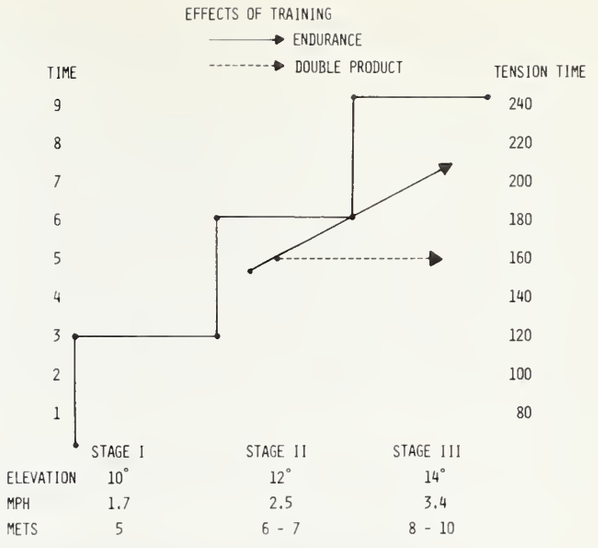
1. Less increase in heart rate and systolic blood pressure.
2. Decreased or absent angina pectoris.
3. Decreased ST-T changes on the EKG.
4. Less increase in the calculated tension time index or double product for the same amount of external work (the double product or the product of the heart rate multiplied by the systolic B/P is considered to correlate well to myocardial oxygen uptake).[4]



Graph 2 shows the effects on double product of three months training in a 40-year-old male who had aorto-coronary bypass surgery.



Graph 3 shows the effects of training on endurance or length of time on the treadmill in fourteen patients after three months training.



Graph 5 is the comparison of the average double product and the exercise endurance before and after three months training in the same group of fourteen patients. The exercise tolerance increased but the double product at which the patients developed angina remained the same.

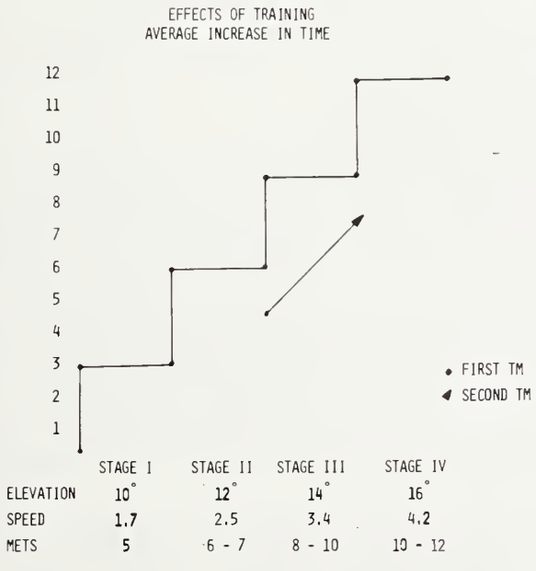
There is improvement in the anxiety and depression scores on standard psychological tests and improvement in the patient's sense of well-being, in his self-confidence, and in his self-esteem.

Graph 1 shows the effects of three months training on a fifty-four-year old male, who had experienced a myocardial infarction. The first treadmill was done four weeks post-myocardial infarction. The top line represents the double product from the first treadmill at 105.3 initially and rising to 167.3 in four minutes, which was the point where he developed angina. He was enrolled in the rehabilitation program; and after three months training, according to the aforementioned protocol, a second stress test was done. The bottom line indicates the initial double product index is 74.4 and rising to 166.4 at eight minutes, which was the point of angina.

Graph 2 shows the results of three months training on a forty-year-old man who had A/C bypass surgery. The first treadmill was done ten weeks post-surgery. The top line indicates the double product initially was 122, rising to 205 at four minutes. The bottom line indicates the double product of the second treadmill done after three months training. Initially, the double product was 99, rising to 201 at six minutes.

Both of these cases show that the double product decreased for equal levels of exercise, but remained the same for the threshold of angina.

In the first six months of our outpatient program, fifty-five patients were evaluated. Treadmill testing performed before and after three months of training in the first fourteen patients shown in graph 3 indicate their exercise tolerance had improved significantly. The circles represent the endurance in length of time on the first treadmill and the arrow the same for the second treadmill. Notice there are two cases in which tolerance decreased. Both of these patients had coronary artery disease — one was severe, who went on to have A/C by-



Graph 4 shows the average increase in endurance or length of time in the same group of fourteen patients.

pass surgery, and the other was not following our recommended exercise program, and his tolerance decreased. Since that time, his tolerance has improved substantially. Graph 4 depicts the group average for exercise tolerance; it rose from 4.5 minutes to 7.4 minutes, or a 60% increase after three months training. Graph 5 compares the average double product and the exercise endurance before and after training.

The exercise tolerance was increased but the double product at which the patients developed angina remained the same.

The outpatient program was financed with a separate budget. Capital expenditures for the new program were approximately $24,000. This was for the cost of the treadmill, bicycles, monitoring and other equipment.

The budget was based on having 20 patients for the first year. We allowed $30,000 for salaries, social security, travel, and maintenance of equipment.

The cost to the patient for the full year is $1,500 with the third party covering 80% of the cost.

In conclusion, we feel that utilizing resources available in a community hospital, we can provide a service that will fulfill the needs of the new dimension of care, cardiac rehabilitation.

References

1. Fletcher, G., Cantwell, J., Exercise and Coronary Heart Disease, Springfield, Illinois, Charles C. Thomas, 1971.

2. Hackett, T., Lassem, N. H., Coronary Disease — Psychological Factors, Exercise Testing and Exercise Training in Coronary Heart Disease edited by Naughton, J. P. and Hellerstein, H. K., Academic Press, 1973.

3. Hellerstein, H. K., Physical Activity Program in the Coronary Care Unit, Olive Branch Conference-Rehabilitation of the Coronary Patient, American Heart Association, 1974, p. 94.

4. Hellerstein, H. K., Exercise Therapy in Coronary Disease, Bulletin of the New York Academy of Medicine, Vol. 44, No. 8, p. 1028, August, 1968.

5. Wenger, N. K., Coronary Care — Rehabilitation After Myocardial Infarction, American Heart Association, 1973.

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Nosocomial Infections At A Children's Hospital

WALTER J. EXON, MD
WILLIAM HINZ, MD
HARRIS D. RILEY, JR., MD

A surveillance study revealed that 26 of 389 patients in a children's hospital developed infections during hospitalization. Various factors influencing the type and nature of these nosocomial infections are analyzed.

Nosocomial infections pose an ever-increasing threat to the hospitalized patient. Infection rates vary from hospital to hospital, but are usually reported to be between 2.8%[1] and 15.5%.[2] Despite dramatic advances in diagnosis and antimicrobial therapy, the incidence of hospital-acquired infections has increased.[3,4] Many reasons are given for this increase, but three seem to be especially important.

First, nearly every new antimicrobial drug inevitably selects out bacterial strains resistant to the antibiotic. Antibiotics given prophylactically to the hospitalized patient may thus encourage the growth of a new organism resistant to that antibiotic. Second, as a result of the improved treatment of neoplastic and other serious diseases, more patients are being maintained in a debilitated condition which predisposes them to infection. And third, as new techniques of diagnosis (cystoscopy, cardiac catheterization) and therapy (administration of immunosuppressive drugs, bone marrow transplantation, intravenous hyperalimentation) are introduced, the anatomic and physiologic integrity of the patient's defense system is impaired and he becomes more susceptible to infection.

Not only are hospital-acquired infections increasing in frequency, their nature is also changing.[3] Although staphylococci continue to be responsible for many hospital-acquired infections, gram-negative bacilli appear to be the most important pathogens,[4,5] and fungi are being isolated more often.

METHODS

A 30-day study was conducted at Children's Memorial Hospital, a 147-bed general pediatric hospital in Oklahoma City, and the Neonatal Special Care Nursery in the adjacent University Hospital. Patients on the following

From the Department of Pediatrics and the Children's Memorial Hospital, University of Oklahoma Health Sciences Center, and the Oklahoma Department of Institutions, Social and Rehabilitative Services, Oklahoma City, Oklahoma

services were included: pediatric medicine, pediatric surgery, urology, orthopedics, plastic surgery, otorhinolaryngology, thoracic surgery, neonatal special care, ophthalmology, and neurosurgery. The 389 patients ranged in age from newborn to 20 years.

At the start of the study, a standard hospital infection report was completed for each patient. Ward rounds were made each morning and included a meeting with the nursing supervisor. The chart of each new patient and the daily temperatures of all patients were reviewed. Although closest attention was paid to temperatures recorded the previous evening, those taken that morning were also scrutinized according to the methods suggested by Konerding and Moffet.[6] Next, a brief conference was held with the head nurse on each ward, and those patients whom she reported as showing evidence of infection were seen by the surveillance officer. Patients thought to be predisposed to hospital-acquired infections (such as those with urinary catheters and intravenous catheters) were seen daily. Staff members from the various services were available for consultation as needed.

Bacteriologic cultures were ordered by the house staff on the wards, with plates prepared by the infectious disease laboratory according to standard techniques. Susceptibilities were determined by the Kirby-Bauer disk method. The laboratory reported the results daily, all positive cultures were recorded, and efforts were made to determine whether the positive culture represented a hospital-acquired infection. A nurse in the Outpatient Clinics of Children's Hospital was responsible for reporting all infections that could have resulted from previous hospitalization of the patient or his family.

For the purposes of this study, infections were classified as "nosocomial" if they met the criteria set forth by the Communicable Disease Center in the National Nosocomial Infections Study.[7]

RESULTS

Surveillance of 389 patients detected 40 hospital infections in 26 patients. Thus, the hospital infection rate (number of infections/number of admissions) was 10%. Six patients (23% of all those developing nosocomial infections) had

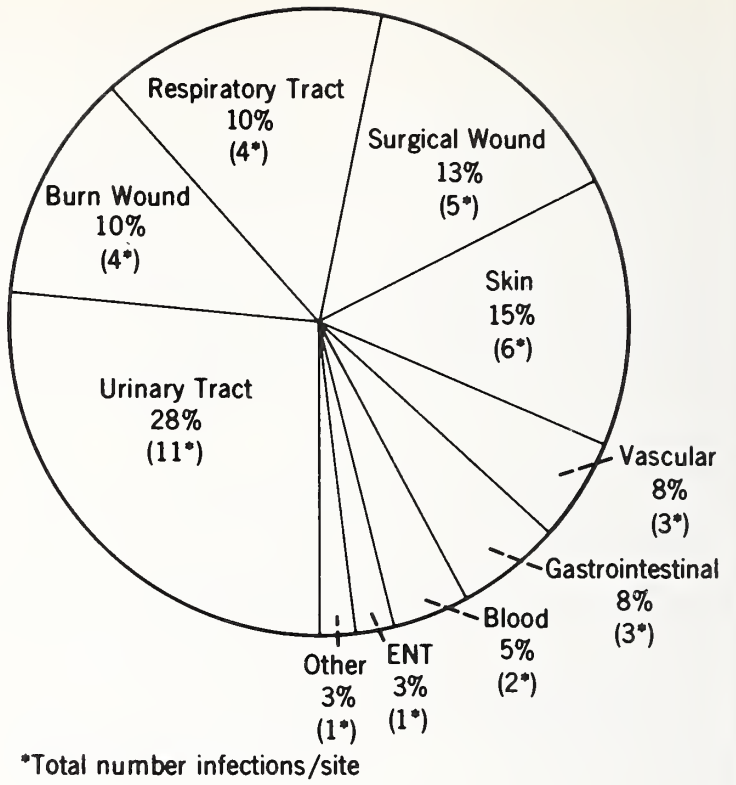


FIGURE
SITE OF NOSOCOMIAL INFECTION. The number followed by an asterisk (*) indicates total number of infections per site.

more than one organism isolated simultaneously from the site of a nosocomial infection. Seven patients had more than one nosocomial infection: one patient had six, three patients had three, and three patients had two. One death occurred, resulting in a case fatality rate of 4%. Nine (35%) of the 26 patients required an estimated 115 days of additional hospitalization because of the infection.

Site of Infection: The incidence of nosocomial infection by site of infection is shown in the

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Walter J. Exon, MD, was graduated from the University of Oklahoma College of Medicine in 1973. He took his residency training in pediatrics at Baylor College of Medicine, Houston, Texas.

A 1964 graduate of George Washington University School of Medicine, William Hinz, MD, served a Fellowship in Pediatric Infectious Diseases at Children's Memorial Hospital, University of Oklahoma in 1970-1971.

Harris D. Riley, Jr., MD, was graduated from Vanderbilt University School of Medicine in 1948. He is now Professor of Pediatrics at the University of Oklahoma Health Sciences Center. Certified by the American Board of Pediatrics, Doctor Riley is a member of the Society For Pediatric Research, the American Pediatrics Society and the Infectious Disease Society of America.

figure. Infections of the urinary tract were the most numerous, and all except one were preceded by prolonged (13 days average) vesical catheterizations, two of which were suprapubic. Only one patient who had prolonged catheterization did not develop a urinary tract infection.

Incidence of Nosocomial Infection by Service: Although 33% of the total infections occurred on the Pediatric Service, this represented an infection rate of only 7% since the Pediatric Service admitted the largest number of patients (132). The highest rate (20%) occurred on the Thoracic Surgery Service, but this was based on infection in only one of five admitted patients. Of 27 patients admitted to the Pediatric Surgical Service, five developed a total of 14 infections for a rate of infection of 19%.

Incidence of Nosocomial Infection by Age: The 12-14 year age group had the highest rate of infection (23%), accounting for 25% of all infections. The next highest rates were in the 15-17 year (17%) and the 9-11 year (16%) age groups. One-third of all infections occurred in the 0-2 year age group, but since this group included 149 of the total 389 patients surveyed, the rate was only 9%.

Etiology of Nosocomial Infections: Most (80%) of the infections were due to bacteria. Five per cent of the infections were due to fungi from patients; cultures yielded both bacteria and fungi. In four instances no organism could be isolated, and in one instance a culture was not performed.

Microorganisms Recovered from Nosocomial Infections: The microorganisms recovered from the 40 infections are shown in Table 1. Of the 40 infections, 29 were due to an organism recovered in pure culture; 11 infections were due to a combination of bacteria. *Staphylococcus aureus,* coagulase-positive, was the most frequently recovered organism (10); only 14 of the total 40 infections were due to gram-positive bacteria, and 23 were due to gram-negative bacteria.

In Vitro Susceptibility of Microbial Isolates: Table 2 shows the in vitro susceptibility of bacterial isolates, as determined by the Kirby-Bauer disk method. All staphylococci (coagulase-negative and positive) isolated were resistant to penicillin-G, but susceptible to methicillin, cloxacillin, and oxolinic acid. Isolates of *Escherichia* were sensitive to colistin and gentamicin. All isolates of enteropathogenic *E. coli* were susceptible to kanamycin, colistin, and gentamicin.

TABLE 1: MICROORGANISMS RECOVERED

	PURE CULTURE OR SOLE PATHOGEN		TOTAL ISOLATES	
	NO.	PERCENT	NO.	PERCENT
Staphylococci (Coagulase-positive and negative)	10	35%	11	28%
Streptococci (Group A and Group D)	3	10%	3	8%
Gram-negative Bacilli	14	48%	23	58%
Fungi	2	7%	3	8%
Totals	29		40	
Staphylococci (Caogulase-positive)	9	31%	10	25%
Staphylococci (Coagulase-negative)	1	4%	1	3%
Streptococcus fecalis	2	7%	2	5%
Alpha-hemolytic streptococci	1	4%	1	3%
Escherichia coli	6	21%	9	23%
Klebsiella	3	10%	6	15%
Pseudomonas aeruginosa	2	7%	4	10%
Enteropathogenic *Escherichia coli*	2	7%	2	5%
Proteus mirabilis	1	4%	2	5%
Candida albicans	2	7%	3	8%
Totals	29		40	

a Includes pure and mixed cultures

Distribution of Infection by Site and Organism: Most urinary tract infections were caused by gram-negative organisms (*E. coli, Pseudomonas, Klebsiella,* and *Proteus*). Coagulase-positive staphylococci were responsible for two of the four reported respiratory tract infections. Staphylococci and *E. coli* were responsible for most wound infections (occurring on the pediatric surgery, orthopedic, and thoracic surgery services).

Distribution of Nosocomial Infections by Service and Site: The skin and soft tissues were most commonly infected (15). Next in frequency were urinary tract infections (11), ten of which occurred on one of the surgical services. Two patients had septicemia.

Signs of Nosocomial Infection: Some patients showed more than one clinical sign of infection while others showed none. The most common indications of infection during hospitalization were the occurrence of purulent exudate and spiking fever. Each of these occurred in about one-fourth of the patients developing nosocomial infection.

TABLE 2: IN VITRO SUSCEPTIBILITY OF BACTERIAL ISOLATES

ORGANISM	TOTAL ISOLATES (No.)	Number of Isolates Resistant														
		Ampicillin	Carbenicillin	Cephalothin	Chloramphenicol	Colistin	Gentamicin	Kanamycin	Tetracycline	Erythromycin	Lincomycin	Methicillin	Oxacillin	Vancomycin	Penicillin	Cloxacillin	Oxalinic Acid
Streptococci[a]	3	–	–	1	–	–	–	–	–	2	2	2	2	0	2	2	–
Staphylococci (coagulase-positive and negative)	11	–	–	0	0	–	–	–	–	5	3	0	2	1	9	0	0
Escherichia coli	7	6	3	1	2	0	0	1	4	–	–	–	–	–	–	–	–
Pseudomonas aeruginosa	3	3	0	3	3	0	0	3	3	–	–	–	–	–	–	–	–
Klebsiella	5	5	3	0	0	0	0	0	3	–	–	–	–	–	–	–	–
Enteropathogenic *Escherichia coli*	2	2	2	2	2	0	0	0	2	–	–	–	–	–	–	–	–
Proteus mirabilis	2	1	0	0	0	1	0	0	2	–	–	–	–	–	–	–	–
TOTAL	33																

a Includes alpha-hemolytic streptococci (Group A) and *Streptococcus fecalis* (Group D).

DISCUSSION

The ten per cent rate of hospital-acquired infections reported in this study is somewhat higher than the 6.5% reported by Roy *et al*[8] and the 5.3% reported by McNamara *et al*.[4] One reason for this difference seems to be the definition and calculation of "infection rates." The study of Roy *et al*[8] was done over a decade ago and involved a larger number of patients, probably accounting for the differences as hospital infections have increased since then. The patient population of McNamara *et al*[4] was considerably smaller than ours but also studied several years earlier.

Urinary tract infections were the most common hospital-acquired infections during the study, consistent with results obtained by other investigators.[5,10] As mentioned previously, all of the urinary tract infections except one were preceded by catheterization. Prolonged urinary tract catheterization is a significant hazard to the hospitalized patient. Infection need not be a sequelae of prolonged catheterization, however, as reported by other investigators.[11-13]

The respiratory tract has been reported by some investigators to be the most common site of nosocomial infections,[4,8] but it accounted for only 10% of all nosocomial infections during this study. It was unusual that no gram-negative respiratory tract infections occurred during the study. Although these infections are usually associated with inhalation therapy equipment such as was used during the study, the relatively low incidence of chronic obstructive lung disease in children and the adequate cleaning and decontamination of respiratory assistance equipment by the Inhalation Therapy Unit probably explain their absence.

As noted previously, the surgical service had a high infection rate (52%), but only three infections (11%) were actual postoperative complications. This figure is still somewhat higher than the 7.4% reported in a reliable prospective study of this problem.[14]

Intravenous catheterization was a significant cause of infections in this study. Several instances of serious systemic infections associated with the use of indwelling intravenous catheters have been reported from this hospital.[15] Only 5% of patients in the present study with an intravenous catheter in place over 48 hours developed phlebitis (documented by positive culture and clinical signs of infection). This rate is quite low compared to that reported by Collins *et al.*[16] The reason is probably infrequent use of polyethylene intravenous catheters in pediatric patients. Most catheters were of the "scalp-vein" type, and most investigators report that these seldom become infected. Some authors, however, have shown that "scalp-vein" needles do serve as a focus of infection,[17] particularly in children with neoplastic diseases.[18]

In another study,[8] staphylococci were the organisms most often responsible for nosocomial infections. In the present study, staphylococci accounted for about one-fourth of the isolates and were important in burn, skin, and respiratory tract infections. Most investigators have found gram-negative nosocomial infections to be the most prevalent.[2,4,5,10,11] Similar results were obtained in this study, with over one-half (58%) of the infections being due to gram-negative bacteria. Gram-negative bacteria were particularly common in urinary tract infections, accounting for about 80%. McNamara *et al*[4] and Sanford[19] report similar findings.

In general, bacteria isolated from nosocomial infections show a fairly high degree of antibiotic resistance. This is not surprising, and is at least partly due to the widespread use of antibiotics in hospitalized patients. Other factors such as diagnostic and therapeutic radiation may contribute to this problem.[20]

The infections reported during this study resulted in 115 extra inpatient days. At an estimated cost per patient day of $85 (not including the cost of diagnostic and therapeutic procedures), the price of these hospital-acquired infections totaled about $9,800.

Because nosocomial infections continue to present a serious threat to the hospitalized patient, the hospital surveillance officer should be an integral part of the health care team. He should monitor all infections occurring in the hospital and follow patients who are particularly prone to infection. Careful review of the data collected can be expected to reveal epidemiological patterns, problem areas, effectiveness of new techniques, and other information. Thus, the hospital surveillance officer may be of direct benefit in providing better patient care.

Summary

A one-month surveillance study of nosocomial infections conducted in a pediatric hospital found that infections developed in 26 of 389 patients during hospitalization. Seven of these patients had more than one hospital-acquired infection, making a total of 40 infections. The hospital infection rate (number of infections/number of admissions) was calculated to be 10%. Urinary tract infections were the most common, and all except one were preceded by catheterization. Gram-negative organisms were the most commonly isolated organisms, accounting for 58% of all isolates. In general, the isolated organisms showed a high degree of antibiotic resistance. A total of 115 days of extended inpatient care were necessary because of nosocomial infections, costing the hospital a minimum of $9,800. The importance of a designated individual to serve as surveillance officer in the control of hospital-associated infection is discussed.

REFERENCES

1. National Nosocomial Infections Study, U.S. Center for Disease Control, Publication No. 7, July, 1970, p. 5.

2. Barrett, F. F., Casey, J. I., and Finland, M.: Infections and antibiotic use among patients at Boston City Hospital. *New Eng J Med* **278:**5 1968.

3. Riley, H. D., Jr.: Hospital-associated infections. *Ped Clin N Amer* **16:**3:701, 1969.

4. McNamara, M. J., Hill, M. C., Balows, A., et al: A study of the bacteriologic patterns of hospital infections. *Ann Int Med* **66:**480, 1967.

5. Adler, J. L., Burke, J. D., and Finland, M.: Infections and antibiotic usage at Boston City Hospital. *Arch Int Med* **127:**360-465, 1971.

6. Konerding, K. and Moffet, H. L.: New episodes of fever in hospitalized children. *Amer J Dis Child* **120:**515-519, 1970.

7. Outline for surveillance and control of nosocomial infections. U.S. Department of Health, Education and Welfare, Center for Disease Control, September, 1970.

8. Roy, T. E., McDonald S., Patrick, M. L. et al: A survey of hospital infection in a pediatric hospital. *Canad Med Assoc J* **87:**531-538; 592-599; 656-660, 1962.

9. Thoburn, R., Fekety, F. R., Jr., Cluff, L. E., et al: Infections acquired by hospitalized patients. *Arch Int Med* **121:**1, 1968.

10. National Nosocomial Infections Study, Publications 1-7, National Center for Disease Control, January 1970 —July 1970.

11. Editorial. Prevention of urinary tract infection. *Modern Treatment,* March 1970, pp 300-307.

12. Sanford, J. P.: Treatment and prevention of opportunistic infections of the urinary tract. *Modern Treatment,* **3:**1162, 1966.

13. Andriole, V. T., Stamey, T. A., Kunin, C. M., et al: Preventing catheter-induced urinary tract infections. *Hosp Pract* **3:**61-68, 1968.

14. Postoperative Wound Infection. Report of an Ad Hoc Subcommittee of the Committee of Trauma, Division of Medical Sciences, National Academy of Sciences.

15. Rubio, T., Riley, H. D., Jr.: Serious systemic infections associated with the use of indwelling intravenous catheters. *South Med J* **66:**633-637, 1973.

16. Collins, R. M., Braun, P. A., Zinner, S. H., et al: Risk of local and systemic infection with polyethylene intravenous catheters. A prospective study of 231 catheterizations. *New Eng J Med* **279:**340-343, 1968.

17. Lloyd-still, J. D., Peter, G., and Lovejoy, F. H., Jr.: Infected "scalp-vein" needles. *J Amer Med Assoc* **213:**1496-1497, 1970.

18. Lowenbraum, S., Young, V., Kenton, D., and Serpick, A. A.: Infection from intravenous "scalp-vein" needles in a susceptible population. *J Amer Med Assoc* **212:**451-453, 1970.

19. Sanford, J. P.: Hospital-acquired urinary tract infection. U.S. Department of Health, Education and Welfare, Publication No. 00-986, National Conference on Institutionally Acquired Infections, September, 4-6, 1963.

20. Haskin, M. D., Bondi, A., Holmes, R. H., et al: The possible role of hospital radiology departments in cross infection and antibiotic resistant bacterial mutagenesis. *Surg Clin N Amer* **50:**4:945-952, 1970.

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News From The Oklahoma State Department of Health

Animal bites produce a perplexing problem for physicians in Oklahoma. In 1975, 106 cases of animal rabies were confirmed by laboratory testing. Positive skunks (66%) were reported most frequently, followed by cattle (14%), dogs (7%), bats (5%), horses (4%), cats (3%). Wild rodents such as rats, mice, gophers, ground squirrels and rabbits have not proven to be a significant human rabies threat. From 1971-1975, 1,649 wild rodents were tested and *none* were found to be positive for rabies.

Since the implementation of the fluorescent rabies antibody test in the late 1960's the necessity of an observation period for biting animals has been eliminated. The following two statements are offered to reduce confusion concerning the disposition of a biting animal:

1) Unimmunized biting animals suspected of being rabid can be immediately sacrificed and the brain examined for rabies by the fluorescent antibody (FRA) technique. Therefore, it is neither necessary nor recommended that animals suspected of having rabies be observed for signs and symptoms of the disease.

2) An apparently healthy domestic dog or cat that bites a person must be captured, confined, and observed by a licensed veterinarian for 10 days. In specific situations an apparently healthy domestic animal may be sacrificed immediately and tested for rabies.

These guidelines are only general recommendations. Guidelines that will cover all exposure situations are virtually impossible to present in written form. Staff members of the Epidemiology Program are available to assist in treatment recommendations in specific bite situations. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR JULY, 1976

DISEASE	July 1976	July 1975	June 1976	Total To Date 1976	1975
Amebiasis	3	7	1	8	16
Brucellosis	4	—	1	7	3
Chickenpox	42	20	90	1556	944
Encephalitis, Infectious	2	10	—	12	31
Gonorrhea (Use Form ODH-228)	1297	1133	1033	7496	7254
Hepatitis, A, B, Unspecified	90	54	75	905	500
Leptospirosis	1	—	—	1	—
Malaria	1	—	—	1	1
Meningococcal Infections	—	—	—	18	9
Meningitis, Aseptic	2	18	—	11	36
Mumps	21	24	28	648	173
Rabies in Animals	7	7	19	90	72
Rheumatic Fever	2	1	—	10	7
Rocky Mountain Spotted Fever	33	17	18	68	67
Rubella	6	—	1	54	82
Rubella, Congenital Syndrome	—	1	—	—	1
Rubeola	5	9	15	286	126
Salmonellosis	42	16	32	136	102
Shigellosis	9	29	5	142	196
Syphilis, Infectious (Use Form ODH-228)	12	5	10	70	47
Tetanus	—	—	—	—	—
Tuberculosis, New Active	32	19	32	207	192
Tularemia	1	1	1	7	6
Typhoid Fever	—	—	—	—	—
Whooping Cough	5	4	4	10	19

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all ds of scrutiny. Your control over patient therapy is ng monitored, judged and occasionally abrogated, netimes by unknown third parties.

The worry is that in the wake of this focus, the rela- nship between you and your patient will be weakened, hout offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, ulations or professional custom stipulate that your n-generic prescriptions be filled with the precise prod- s you prescribe. But in the last five years, a dozen or re State laws have been changed, permitting the phar- cist in most cases to select a product of the same eric drug to fill any prescription.

Ironically, this dilution of physician control has en place against a background of growing evidence purportedly equivalent drug products may be in- ivalent, since neither present drug standards nor their orcement are optimal. In fact, the FDA itself says it not enforced the same standards for hundreds of low-on" products that it had applied to the original A approvals. Thus physician control over patient apy is being eroded with a risk that patients may be osed to drugs of uncertain quality.

The major advertised claim for substitution is reduced cription prices for consumers. Yet no documentation ny significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is deral regulation designed to cut the Government's g bill by setting price ceilings for drugs dispensed to licare and Medicaid patients. Unless the prescriber ifies on the prescription that a particular product is ically necessary, the Government intends to pay only he cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

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OSMA JOURNAL / *news*

HSA Network Nears Completion

The Oklahoma Health Systems Agency, Inc., a health planning network established under PL 93-641, has entered its last stages of formation and apparently will soon be in high gear. The OSMA has continued to oppose this type of federally mandated health planning but has cooperated in its formation since it is required by law and in order to assure the best possible representation by the profession.

In Oklahoma one HSA board will be responsible for ultimately deciding health planning throughout the state. Members of this board were appointed by Governor David L. Boren some months ago from a list of nominees submitted by both consumer groups and organizations representing the medical profession and allied health groups. This board is made up of 16 consumers and 14 "health care providers," which is the maximum provider representation allowed by law.

Under this board and responsible to it are six subarea councils which will initiate the planning processes at the local level. Each subarea is responsible for determining health priorities based on the particular needs of that area of the state. These subarea councils will file reports with the HSA board which will be used to establish statewide planning priorities. Although HEW will have ultimate authority over health planning, including facility construction, recommendations made by the HSA board, the subarea councils and the Oklahoma Health Planning Commission, are expected to have considerable influence on the department's decisions.

During the last few weeks most of HSA's attention has been given to the selection of the subarea councils. These councils are also made up of 30 members selected from a list of nominees submitted by medical and consumer groups. Actual selections to the council are made by the subarea trustees who are members of the HSA board representing that area of the state. After the trustees selected their choices for the council, public hearings were held in which the membership by any particular individual could be challenged. In each case 14 providers and 16 consumers have been selected.

Although the overall selection process has only recently been completed, health planning under the HSA system has already begun. On September 16th, the HSA board ruled on five proposed facility construction projects. In the future, all such projects will first be considered by the HSA planning network. □

Swine Flu Program Approved

Having dispensed with the professional liability question shortly before Congress adjourned for the Republican National Convention, the way now seems to be cleared for the nationwide swine flu immunization program. Only hours before Congress recessed, it passed a law which will provide professional liability insurance for participants in the program which was originally called for by President Gerald Ford.

The act by Congress amends the Public Health Service Act and authorizes the Secretary of HEW to oversee the national program. Secretary David Matthews will be required to keep close tabs and report back to the Congress on: the supply of the vaccine; the number of persons vaccinated; the cost of the program; and the epidemiology of influenza.

The law itself establishes a procedure through which the United States government can offer insurance to physicians and paramedical personnel who help in administering the vaccine. One very important disclaimer has been placed on the insurance, however, and should be noted by all physicians who plan to take part.

According to the law, any claim which arises from the innoculation program will be brought directly against the United States government, provided the person involved administered the vaccine in compliance with the informed consent forms and at no cost to the recipient. If, however, a physician chooses to charge for administering the vaccine, he will not be covered under this act.

Government will provide the vaccine at no cost to the physician. However, it is expected most physicians administering the vaccine in their office will charge a small fee to cover the cost of syringes, cotton, alcohol, etc.

Another important stipulation physicians

should be aware of is the fact that government, under this law, has the right to recover any damages that result from failure of the participant to fulfill the contractual agreements of the program or that can be attributed to negligence on the part of the participant. If, for example, a physician failed to have a patient sign the informed consent form, and based upon that damages were awarded and paid by the government, the physician could ultimately be held responsible and government could recover its losses. In the event this occurred, the physician's private, professional liability insurance would be in effect as it would in any similar instance.

Armond Start, MD, Director of the Oklahoma State Health Department's Communicable Disease Control Program, says the swine flu vaccine will be approved by the Food and Drug Administration and will not present any more of a liability problem than any other approved biologic which is administered in a physician's office. Doctor Start admits, however, that the large numbers of persons to be vaccinated under this program will probably present some problems due simply to the volume.

Because of the unexpected problem in securing adequate protection, the distribution time-table originally announced by the Health Department will probably be set back several weeks. Department officials now expect to receive the first shipment of vaccine during early October. Originally it was expected the vaccine would be delivered around September 1st.

According to the State Health Department, the responsible administrative agency for the program in this state, the vaccine will be distributed in two phases. Physicians will first receive the bivalent vaccine [A/Victoria vaccine and A/New Jersey (swine) vaccine] which is intended for the high risk population. This group includes persons over age 65 and persons between the ages of 18 and 65 who have chronic health problems.

Although the bivalent vaccine is actually intended for those two groups, physicians are expected to use clinical judgment in determining other persons who should receive it. For example, a person under age 18 with chronic health problems would probably be immunized using a reduced dosage schedule. The bivalent vaccine will be supplied at no cost to physicians by the local county health department or county coordinator. Although the State Health Department will oversee the entire operation, distribution in each county will vary according to geographic and population requirements. County coordinators or the county health department will contact each physician and work out plans to deliver the vaccine or make it available.

There are no plans to administer the bivalent vaccine at mass innoculation centers; it will be administered in physician's offices, in care centers such as hospitals or nursing homes and at local county health departments.

The monovalent vaccine (A/New Jersey only) will probably be available approximately two or three weeks after the bivalent vaccine. It will again be distributed by county health departments and county coordinators, but it will also be offered at community-based mass immunization centers. It is designed for use among the healthy population, ages 18 to 65.

At this point no vaccine for persons under age 18 has been developed. When it is, it will be distributed in a similar manner and offered at school-based clinics. The target date for this population group is November.

Any physician wanting additional information should contact his local county health department, his county coordinator or the State Influenza Project office at (405) 271-5603. □

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Mental Health Due Special Attention

A special legislative Committee on Health Care Delivery Systems will apparently take a close look at Oklahoma's mental health program during the Legislature's interim session. According to Senator Al Terrill, committee chairman, four interim meetings will be devoted to studying the state's mental health system. The study plan was approved at the committee's first meeting on August 12.

The first of these study meetings took place on September 9th and was called in order to begin considering the need to rewrite the laws dealing with admission to a state mental hospital, especially involuntary admission.

On September 30th, officials from the State Department of Mental Health will appear to review the present status of the program and report on what they feel will be needed in the way of legislation during the next five years. This meeting will be followed on August 7th by a critique of the department's report. All agencies interested in or involved in mental health will be invited to appear at this meeting.

The last of the four interim meetings, scheduled for November 11th, will be devoted to consideration and adoption of recommendations for presentation to the Executive Committee of the Legislative Council. These recommendations will largely determine what, if any, action the Legislature will take during its next regular session.

Although the committee is expected to take a broad look at mental health laws, special attention will apparently be given to the state's involuntary admission procedure. Senator Bob Funston, chairman of the subcommittee on mental health, said Oklahoma's law includes an elaborate system for protecting persons accused of committing a crime but does not include the same type of protection for those who are suspected of mental illness or of being mentally incompetent.

Senator Funston is expected to push for legislation to correct this situation during the next legislative session. □

ANNOUNCING
OKLAHOMA CITY CLINICAL SOCIETY
M.D. DAY '76
GENERAL INFORMATION

REGISTRATION — Friday, October 22nd, 10:45 a.m. at Oklahoma University Health Sciences Center. Box lunches will be furnished those who preregister and request lunch.

FEES — OCCS Members: Included in 1976 Dues. All others: $25.00. This includes box lunch and social hour on Friday, Continental breakfast, box lunch and transportation to the game for physicians and wives on Saturday.

PROGRAM — Friday, October 22nd: 11:15 a.m.-5:00 p.m. Saturday, October 23rd: 7:30 a.m.-10:45 a.m. To be presented by OU College of Medicine Faculty. Wives and special guests are welcome. Acceptable for seven hours AMA Category I Credit.

ENTERTAINMENT — Tours of Medical Center for wives Friday p.m. Social hour honoring Emeritus Faculty Friday evening. Physicians, wives and guests invited. (Dinner by individual arrangement.)

OU-OSU FOOTBALL GAME — Bus transportation will be provided to the game in Norman. Box lunches will be furnished. Tickets to game **NOT** included.

Detailed program and advance registration form will be mailed soon.

ATTENTION OSMA DELEGATES: A called meeting of the OSMA House of Delegates has been scheduled for Sunday, October 24th, 10:00 a.m. at the **Hilton Inn, Northwest.** Delegates are encouraged to attend M.D. Day '76, which is approved for 7 hours AMA Category I Credit.

DEATHS

BEVERLY JEANNE BURDETTE, MD
1927-1976

Beverly Jeanne Burdette, MD, an Oklahoma City anesthesiologist, died July 31st, 1976, in Oklahoma City. A native of Wichita, Kansas, Doctor Burdette was graduated from Washington University School of Medicine in 1953. She had practiced in Kansas City, Kansas and Kansas City, Missouri before coming to Oklahoma City. She was a member of the American Society of Anesthesiologists.

LLOYD C. BOATRIGHT, MD
1901-1976

Oklahoma City, retired physician, Lloyd C. Boatright, MD, 74, died August 6th, 1976. Born in Conway Springs, Kansas, Doctor Boatright came to Oklahoma City in 1919. He was graduated from the University of Oklahoma College of Medicine in 1931. His private practice was established in Oklahoma City where he remained until his retirement in 1973. Doctor Boatright was a Life Member of the Oklahoma State Medical Association and a member of the Oklahoma City Clinical Society.

MAURICE J. SEARLE, MD
1893-1976

Maurice J. Searle, MD, 82, Past-President of the Tulsa County Medical Society, died July 25th, 1976, in Tulsa. Born in DuBois, Pennsylvania, Doctor Searle was graduated from Jefferson Medical College in 1920. He established his practice of pediatrics in Tulsa in 1922. In 1970 Doctor Searle was named Tulsa County Medical Society's Doctor of the Year. The Oklahoma State Medical Association honored him in 1972 with a Life Membership for over 50 years of dedicated service to humanity. Doctor Searle was a Fellow of the American Academy of Internal Medicine and was certified by the American Board of Pediatrics. □

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Annual Cancer Forum Scheduled

The Eighth Annual Cancer Forum sponsored by the Arkansas and Oklahoma Divisions of the American Cancer Society will be held September 30th and October 1st at the Sheraton Inn, Fort Smith, Arkansas.

The two-day program includes discussions on malignant melanoma, childhood cancer, cancer diagnosis, cervical cancer, and thyroid cancer. The program was developed in cooperation with the Office of Continuing Medical Education for Physicians of the University of Arkansas for Medical Sciences. Presentations will begin at 10:00 a.m. on September 30th and will close at 3:45 p.m. on October 1st.

Room reservations should be made directly with the Sheraton Inn, Fort Smith, Arkansas 72901. There is no registration fee. The forum is open to all members of the medical profession, registered nurses and medical students.

For more information, please contact the American Cancer Society, 1312 N.W. 24th, Oklahoma City, Oklahoma 73106 or call 525-3515. □

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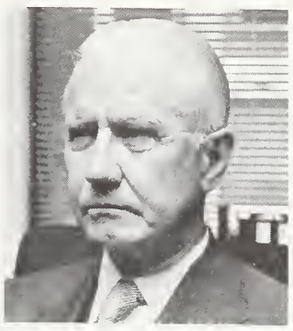
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Oklahoma Physician Reelected To College Board

Oklahoma City physician Joe Henry Coley, MD, has been reelected to a three-year term on Thomas Jefferson University's Board of Trustees. The college is located in Philadelphia, Pennsylvania.



Joe Henry Coley, MD

Doctor Coley, who is Professor Emeritus of Obstetrics and Gynecology at the University of Oklahoma School of Medicine, has served as an alumni trustee of Jefferson since December, 1972. He is a 1934 alumnus of Jefferson Medical College. His father was also a graduate of the college in the class of 1880. □

Pharmacists Seek Changes

Calling it detrimental to the public and a possible factor in encouraging drug abuse, the Oklahoma Pharmaceutical Association has passed a resolution condemning the advertising of prescription drugs. The action, which was taken at the group's 69th annual meeting in Oklahoma City, came only days before the US Supreme Court struck down state laws which prohibit such advertising.

In reaching its decision, the Court ruled that no matter how "tasteless and excessive it sometimes may seem", advertising is nonetheless protected by the first amendment to the constitution. This action apparently clears a way for pharmacies to begin advertising their prescription services through newspaper, radio and television.

According to the Pharmaceutical Association's Executive Director W. W. "Tate" Taylor, the Oklahoma State Board of Pharmacy may still be able to impose some restrictions on advertising in order to protect the public. He said such restrictions would probably be placed on advertising of controlled substances, if indeed they are allowed. Taylor also said that thus far no pharmacy in this state has taken advantage of the court ruling.

In other actions at the meeting, the OPA approved several resolutions which relate directly to the medical profession. Some of the more important medically relevant resolutions are described:

*The OPA urges that all physicians specify whether or not a prescription should be refilled. According to the resolution, this information should be given on the original prescription in order to save both the physician and the pharmacist valuable time.

*The OPA urges that "all prescribers and interns" in hospitals be required to print or stamp their names and Drug Enforcement Administration numbers on prescription orders, as well as sign it, in order to make the prescriber readily identifiable. The OPA resolution states that often hospital prescription orders are presented without the printed name of the physician, and it is therefore impossible to determine who ordered the prescription and whom to contact in case a question arises.

*The OPA urges that only one prescription be written on each prescription blank. The association explained in its resolution that pharmacists must file prescriptions for controlled substances on a separate file and with a separate prescription number.

*The OPA urges that certain nonprescription, over-the-counter medications be sold only under the supervision of a registered pharmacist and through registered pharmacies. The resolution urges that the FDA and other state and federal agencies review these medications which may be inherently toxic, if taken improperly.

*The OPA urges that the dispensing of prescription medications by mail be stopped because it presents a threat to the public and contravenes the physician-patient-pharmacist relationship.

*The OPA urges that Medicare benefits be expanded to include prescribed drugs for home patients. The resolution states that presently the law only allows coverage while an individual is confined in an institution and says it is "senseless and wasteful to provide coverage for necessary physician and diagnostic services without the drug therapy required to properly treat the illness."

*The OPA urges that federal regulations requiring the use of safety closures on all medications be relaxed. The OPA resolution points out that these closures pose considerable problems to patients who, because of age or incapacity, find them difficult to open. Often, it says, the caps are either left ajar or thrown away, presenting considerable hazards to the health of others. □



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Oklahoma Physician Named Neurosurgical Officer

The Rocky Mountain Neurosurgical Society has announced that Oklahoma City neurosurgeon R. Barton Carl, MD, will serve as that group's treasurer during the 1976-77 organizational year. Doctor Carl was elected at the society's meeting held June 13th-16th in Las Vegas, Nevada.

Doctor Carl follows another Oklahoma physician as an officer of the Neurosurgical Society. Robert L. Imler, MD, Tulsa, served as the society's President during 1975-76.

Other officers elected at the meeting are: Javier Verdura, MD, Mexico City, Mexico, President; George Hoffman, MD, Phoenix, Arizona, President-elect; Richard Tozer, MD, Topeka, Kansas, Vice-President; Richard H. Moiel, MD, Houston, Texas, Secretary; and Thomas Craigmile, MD, Denver, Colorado, Historian.

The group will hold its next annual meeting June 8th-12th, 1977, in Lake Tahoe, Nevada. □

St. John Medical Center Schedules Symposium

Three distinguished international experts in the field of tumor immunology comprise the faculty for a symposium to be held at St. John Medical Center, Tulsa, October 20th.

The doctors, all from the Hebrew University of Jerusalem, are: David W. Weiss, PhD, Microbiology and Biochemistry, Medicine Professor and Chairman of the Department of Immunology, Lautenberg Center; Dov Sulitzeanu, MSc, Bateriology, PhD, Bacteriology, and Professor at the University; and Nabil Hanna, BSc, Microbiology and Biochemistry, MSc, Microbiology, PhD, Immunology and Lecturer, Department of Immunology.

Doctor Weiss will speak on "Current Status of Tumor Immunology," and also "Non-Specific Immunotherapy of Cancer." Doctor Sulitzeanu will discuss "Immunodiagnosis of Neoplastic Disease in Man," and Doctor Hanna will explore "The Role of the Macrophage in Resistance against Foreign Cells."

Sessions will be from 1:00-5:00 p.m. in the auditorium of the hospital's administrative services building, 1802 E. 19th Street, and are co-sponsored by St. John's Department of Continuing Medical Education and the Herman P. and Sophia Taubman Foundation. Through courtesy of the Taubman Foundation there is no registration fee, and the symposium is open to all physicians and other interested health care workers.

For more information contact St. John's CME office at 918-744-2065. □

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Tulsa County Medical Society Awards Scholarships

Fourteen area medical students will each receive an educational assistance award of $500 from the Scholarship Fund of Tulsa County Medical Society. Total value of the cash grants for the 1976-77 school year is $7,000.

With two exceptions, all are enrolled at the University of Oklahoma College of Medicine or the new O.U. Tulsa Medical College.

The Doctor Anna Luvern Hays Memorial Scholarships, endowed by the Tulsa pediatrician who died in 1965, went to Douglas G. Cox, George S. Davis, Patrick H. Griffin, Stewart J. Katz, Aletha C. Oglesby, James P. Walker and Mark E. Munson all from Tulsa.

An award in memory of Doctor Margaret G. Hudson, school health official who died in 1973, was given to Sandra Kay Dimmitt, Sand Springs. The scholarship was made possible by a gift from the late Doctor David V. Hudson, husband of Doctor Margaret G. Hudson, who died last January.

The Doctor O. C. Armstrong Scholarship, established by the retired Tulsa family practitioner, was awarded to Stanley A. Horst, Tulsa.

The Doctor Maxwell A. Johnson Memorial Scholarship, named for the Tulsa urologist and medical leader who died in 1971, went to Steven L. Coulter, Tulsa.

The Doctor Frank L. and Jessie O. Flack Scholarship was given to Bruce A. Kraemer, Tulsa. It was created by Mrs. Flack in memory of her husband, Doctor Frank L. Flack, Tulsa surgeon who died in 1963.

For the third consecutive year, the Glenda Ann Cale Memorial Scholarship was given to Susan M. O'Brien, Tulsa. This grant was established by physicians and friends in memory of a 23-year-old Southwestern Bell Telephone Company employee found murdered in 1972.

Two scholarships funded by the Woman's Auxiliary to Tulsa County Medical Society went to Phyllis Anne Bates, Tulsa, and Teresa M. Shavney, Sand Springs.

Griffin is a freshman at Columbia University College of Physicians and Surgeons, and Kraemer is a sophomore at Washington University School of Medicine.

Cox, Oglesby, Shavney and O'Brien were recipients of awards from the non-profit foundation in previous years. □



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Summer Report of the President

The 1976-1977 auxiliary year is under way and many of us are well into our program and working toward our goal.

The national convention was held in Dallas the last week in June with Mrs. James L. Haddock, Mrs. Neil B. Kimerer, Mrs. Ronald Gates, Mrs. William Harrison and Mrs. Elton LeHew attending each session as delegates. Alternate delegates were Mrs. Orange Welborn, Mrs. Ed Calhoon, Mrs. Scott Hendren and Mrs. Joe Crosthwait.

There were 813 members registered for this inspiring, informative and fun meeting of our auxiliary.

A new national seal was chosen. One of the Ohio members submitted the winning seal design.

Oklahoma received an award of merit for the state contribution of $23,555.15. Workshops were held for legislation, membership, AMA-ERF, treasurers, project bank and communications.

Roy Pfautch, Secretary for America Associates of Political Consultants talked to the House of Delegates on "The Mood of America." He stressed voters should start voting for the person rather than the party. He further stated that most Americans feel that at least 60% of the politicians are crooks.

Luncheon speakers were Bess Myerson, a former "Miss America" and now a Consumer Advocate, also Michael E. DeBakey, MD, President and Chairman of the Department of Surgery, Baylor College of Medicine.

Mrs. Norman H. Gardner of Connecticut was installed as National President. She stressed that we stand united in support of our organization; county, state and national. Also that it is our responsibility to promote the health concerns of the AMA.

The summer board meeting was held August 9th at the OSMA building. Committee plans for the year were presented and Mrs. William Harrison presented an AMA-ERF workshop. She had attended a national workshop in Chicago the first week of August.

Mrs. Layton Runkle will attend a legislation workshop in Washington, D.C. in September.

Mrs. Haddock and Mrs. Kimerer attended the OSMA Board of Trustees meeting in July.

A new Legislation Committee has been formed at Doctor Welborn's request to meet with the OSMA Legislative Committee. They are Mrs. Layton Runkle, chairman; Mrs. Chester Bynum, both of Norman; Mrs. Ronald S. Barlow, Mrs. Myron A. Cordum and Mrs. Dan R. Stough of Oklahoma City. They are eagerly awaiting further instructions from the OSMA.

Mrs. Haddock and Mrs. Kimerer attended the second OMPAC Board meeting for this year. With elections coming right up, there is much work to be done and the need of sustaining memberships is most important. I am looking forward to meeting with each auxiliary in the State as well as various remote areas of the State with MAL.

In October, Ellen Kimerer and I will be attending the National Fall Conference and Presidents-elect workshop along with Mrs. Gerald McCullough, Mrs. J. R. Reimer, Mrs. John F. DeJarnette, Jr. and Mrs. Sopan Nakpairat, the four allotted County-Presidents-elect. The State Fall Conference will be held November 1st in the OSMA Building in Oklahoma City. — *Mrs. James L. Haddock, President* □

OSMA JOURNAL / *the last word*

The appropriateness of a physician serving on a county hospital's Board of Control depends upon the type of practice he is engaged in and his relationship with the hospital, says an official opinion released recently by the Oklahoma Attorney General's office. The opinion was rendered at the request of Senator James Howell, D-Midwest City, and Representative Ross Duckett, D-Mustang. According to Oklahoma law, "No member of the Board of Control shall have a personal, pecuniary interest, either directly or indirectly, in any purchases or contracts for said hospital unless the same are purchased or awarded by competitive bids." In some instances this has been interpreted to mean that no doctor who is associated with the county hospital in any way would serve on the Board of Control.

The opinion released July 6, 1976, however, points out that there appear to be three classes of physicians practicing in hospitals: Those who are employed in a "master-servant" relationship; those who are not paid directly by the hospital but who hold an exclusive contract to render a paid service to all patients; and those who are not directly or indirectly paid by the hospital. Although physicians in the first two classes still will not be able to serve on the Board, the opinion makes it clear that those in the third category are eligible since neither a direct nor an indirect interest in purchases and contracts exists and since their sole remuneration is derived directly from patients for services rendered.

Whether a physician has a personal, pecuniary interest in the operations of the hospital is a matter to be individually determined, said the opinion.

Physicians or groups of physicians who volunteer their time and expertise by conducting free physical examinations and treating injuries of boys and girls engaging in school-sponsored athletic programs are not protected by the state's Good Samaritan Acts, says a legal opinion requested by the OSMA. The opinion, given by Roy C. Lytle, LLB, OSMA legal counsel, states, "The fact that the doctor is a good citizen, is interested in athletics, and is willing to contribute his time and expertise without making a charge for it, is not a defense if the plaintiff can prove to the satisfaction of a jury that the doctor was in some way negligent." The opinion was requested to determine if physicians who volunteer their services are liable in the event a condition resulting in an injury is overlooked or if something goes "awry" in the doctor's treatment of an athlete.

Oklahoma has two Good Samaritan Acts. One encourages a physician who comes upon the scene of an accident to render emergency medical treatment by providing that he will not be responsible for civil damages as a result of any act or omission. This act does not apply to physical examinations, nor would it apply to any subsequent treatment when a contract of any type exists.

Under a general statute covering torts, a physician is protected from liability in providing aid under emergency circumstances to prevent probable death or serious bodily injury if it is given in "good faith, voluntarily, and without compensation." Under this statute a physician is not liable for negligence "except for committing gross negligence or willfull or wanton wrongs in rendering emergency care."

Although the opinion cannot promise protection under the Good Samaritan Acts, it does point out that the risk in providing these services is probably less than that which exists in the normal fee-for-service circumstances. It also points out that any physician providing these services would be protected by his own professional liability insurance.

October 24th, 1976, has been established as the date for a special meeting of the OSMA House of Delegates. The Board of Trustees called for this meeting after reviewing House action on a resolution last April which dealt with AMA membership. According to the original decision, if an OSMA member decides not to belong to the AMA, he will not be required to do so, but his dues for membership in the state association must include that amount charged by the AMA ($250). The AMA portion will, in that case, be equitably distributed between the OSMA and the local county medical society. The purpose of the called meeting of the House of Delegates is to reconsider that action. □

The JOURNAL of the Oklahoma State Medical Association

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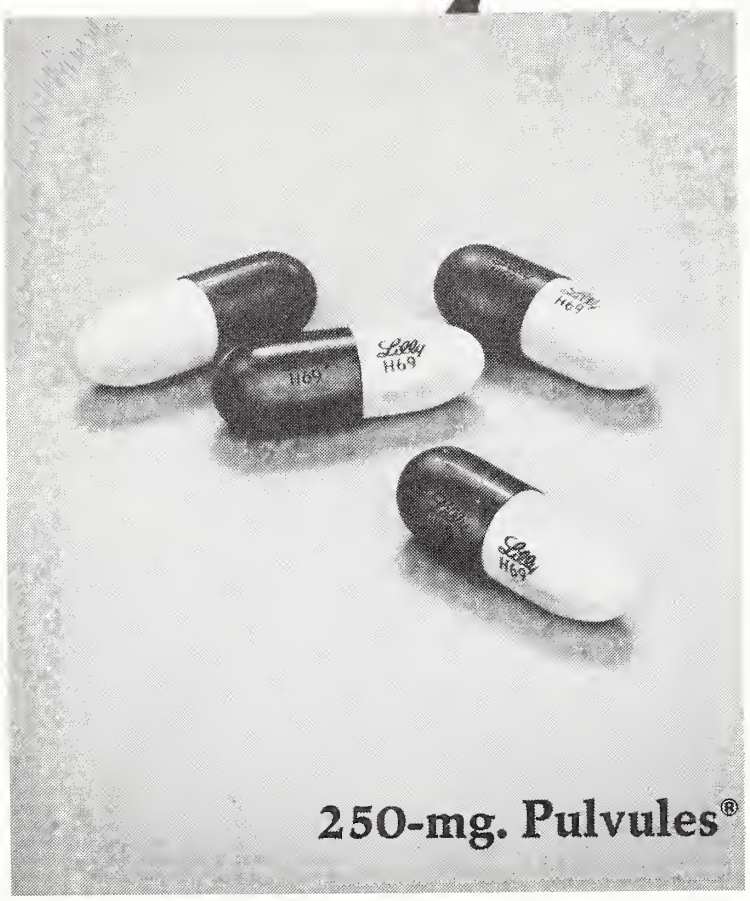
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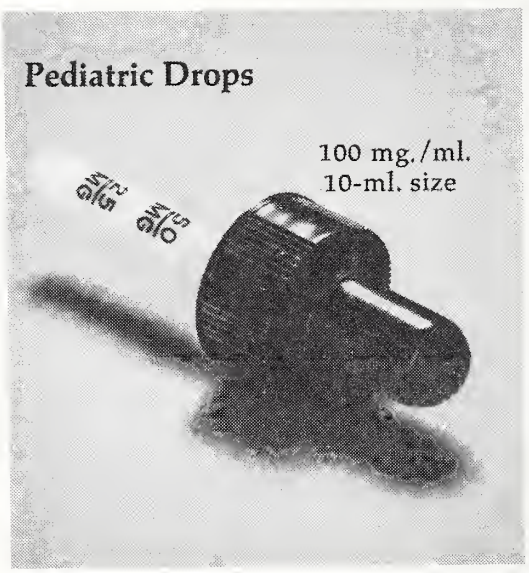
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Doctor Nullus Nemo and His New Department of Melnology — A Satire

OSMA JOURNAL / editorial

The newly formed Medical School of Southern Reserve University was definitely in financial straits. Severe strictures had been put on the dean in his plans for far-reaching developments at the school. In this difficult situation, it occurred to him that he might introduce an imaginary new Department, Melnology, directed by a non-existent Chairman by the name of Nullus Nemo. Doctor Nemo was duly appointed and his appointment confirmed by the Regents of the University. The publicity department gave him a fine build-up in the local press. He also received some national publicity due to the novelty of his field.

At the time of his appointment, Doctor Nemo was still in the Navy to which he owed two more years of service, until he could officially spend full time as Chairman of the Department of Melnology at the medical school. However, during these two years he eagerly set himself the task of recruiting melnologists to form the nucleus of his staff at Southern Reserve Medical School. He was in and out of town and it became a status symbol at the school to have conferences with him on his plans. He, being such an important personality at the center and of such nationwide reputation, one could hardly deny having met him, even if it was only briefly.

The dean supposedly saw him frequently at national conventions and Doctor Nemo was said to have been in and out of Washington to work on a large training grant for his department. When he took over the full time chairmanship of his Department of Melnology in the third year after his original appointment, he and his interesting new field received a great deal of national publicity. When he was in town his secretaries closely guarded him to protect him from visitors while he immersed himself in his laboratory investigations. In keeping with his reputation, he was written up in *Time,* unfortunately without a photograph. "The Square-Up," the weekly publication of Southern Reserve University Medical School, kept everybody well informed on his whereabouts and professional activities. Understandably, the curriculum was properly re-organized to allow for comprehensive training of medical students in Melnology, which has multiple interfaces with many areas of theoretical and clinical medicine.

During his fourth year at the Medical School he founded the American College of Melnology and was editor-in-chief of two journals, the *American Journal of Melnology,* and its more academic counterpart, the *Archives of Melnology,* which reported on investigational advances in the field.

During his fifth year at Southern Reserve he became the head of a Study Section on Melnology at the National Institutes of Health, and a National Institute of Melnology was established in Washington.

But Doctor Nemo was already looking beyond the confines of the nation in preparing the First International Congress of Melnology, for which he was designated President. The Congress took place during his sixth year as Chairman, in a luxurious former harem on the shores of the Mediterranean in North Africa. An excursion to Carthage and a torchlight parade to its ruins were said to have been the highlights of the Congress. Here Doctor Nullus Nemo presented evidence that classical Carthagenians had been familiar with the field of Melnology, although the term itself was of more recent origin. Doctor Nemo's successful Presidency at the Congress brought a good deal of reflected glory to Southern Reserve Medical School. Doctor N. N., as he was affectionately called, somewhat exhausted from the fast pace of the last years and feeling that he was entitled to a period of rest and reflection, asked for a sabbatical leave (which was duly granted) to spend at the Institute of Advanced Studies in Melnology in Hollywood, Florida.

This is where Doctor Nullus Nemo is at present, writing a textbook on Melnology and another work entitled, "Research and Progress in Melnology." It is doubtful whether Doctor Nemo will return to his School. It is reported that he has received many offers and that his name has been mentioned by those in the know as a candidate for the Nobel Prize for his tremendous achievements in this fascinating field.

Recently, the dean has requested the Department of Medical History at the Southern Reserve Medical School to write a biography of its most outstanding faculty member, Doctor Nullus Nemo. *Ernest Lachman, MD*



My term as OSMA President is almost half over —we are now midway between annual meetings. This "President's Page" shall serve as an "Interim Report on the State of the Association."

By the time you receive this report, the House of Delegates will have met at a special called meeting to resolve the dilemma concerning unified membership in organized medicine — local, state and national, or voluntary membership in the American Medical Association. The decision will rest entirely with the House of Delegates and its decision must be "clear cut." No matter what the decision is, I sincerely hope we all remain united in our effort to continue to improve the care we deliver to our patients and to preserve as much freedom as possible in the efforts of the profession and in the practice of medicine.

We need a strong united effort by all physicians on the local, state and the national levels, because dangerous intrusion into the practice of medicine is occurring at each level. I urge every medical doctor to be active and to be a vital part of his local society, our State Medical Association and the AMA.

During the last weekend of October, the Council on Planning and Development will meet; the agenda is very extensive. The council will review the plans and activities of our other six councils and will assess their plans for not only the next six months, but for next year also. Each of our councils is busy with dynamic programs to help every physician, to help our profession and to improve the quality of care for our patients.

The Executive Committee of the OSMA has met each week or two due to a major reorganization of the executive offices. Don Blair has resigned as the Executive Director and he will soon assume a new executive position. Don has given outstanding services to our association over the past 21 years. Fortunately, he will be working in an executive position with C. L. Frates & Co. which handles most of our insurance programs, including our outstanding professional liability program. Mr. Blair will be the executive in charge of the OSMA's program, and as many of you know, he is extremely knowledgeable in insurance problems, especially as they relate to medicine and to the entire health profession. His talents and expertise are not entirely lost to our association, and we are fortunate in that respect.

David Bickham has accepted the position of Acting Executive Director and is already doing an excellent job carrying on the regular functions of the executive office. He is also implementing the reorganization of the office and its functions.

We are very fortunate that Ed Kelsay, Executive Director of the Oklahoma Foundation for Peer Review, has been persuaded to come back to the executive offices on a part-time basis. His talents and his knowledge of the association are invaluable at this critical time.

Ed will continue to serve as Executive Director of the OFPR at a busy time when the new Oklahoma Plan for Utilization Review is about to be initiated. The association is very grateful to Hillard Denyer, MD, President of the Foundation and its Executive Committee for permitting Ed Kelsay to return to the OSMA on a part time basis.

One of the hardest working, most sincere, and most dedicated young men I have known is Richard Hess, the OSMA's Director of Communications. He is especially talented in journalism and in both professional and public relations. In only one year he has become a "seasoned hand." His services to the association are a real asset.

Your association is really beginning to move now — the council reorganization is showing the fruits of success as the dynamic programs of the OSMA become more active and of more service to our members and to the profession. The reorganization of our executive staff and the restructuring of our central offices are showing great promise. All of this will culminate in a more effective association, the attainment of many important goals and the elimination of costly and unproductive programs.

The OSMA is on the move. Much has been done, but there is much more to do before this report can be completed at Summit next May.



OSMA JOURNAL / scientific

Amniocentesis
A brief discussion

PHILIP J. MAGUIRE, MD

Amniocentesis has become an essential part of the modern obstetric armamentarium. A brief discussion is given of the technique and the vast amount of information available from the procedure.

Amniocentesis for the extraction and study of amniotic fluid is not a new procedure. There are reports that radiologists placed dye into the amniotic cavity as early as 1930. In 1950 Bevis[1] began systematic studies of amniotic fluid in what was then often called Hemolytic Disease of the Newborn. A phase of very rapid development of the method began in the 1960's when Liley of New Zealand published his now-well-known findings leading to the present day management of problems of Rh-isoimmunization during pregnancy[2].

Current studies of amniotic fluid obtained by amniocentesis can be divided into several categories:

1. Spectrophotometric
2. Maturation; a. cytologic b. biochemical
3. Genetic
4. Fetal physiology
5. Amniography

The technique of amniocentesis is not difficult. A pelvic examination should precede the procedure. The bladder must be empty. Effort is made to localize the fetal parts as well as the placenta. An area near the midline of the lower abdomen is prepared with antiseptic solution and a spinal needle passed through the abdominal wall and into the amniotic sac. Ten to 15cc of fluid are removed, placed into a dark container and protected from light. Strict aseptic technique is imperative. Generally there is no difficulty in entering the cavity. At 15-to-16 weeks of pregnancy there is approximately 150cc of fluid and an increment of 50cc per week for the next 13 weeks is normal. A review of the technique can be found in the November, 1974 issue of Obstetrics and Gynecology.

Serious complications from amniocentesis occur but the incidence is very low. Complications are fetal and maternal. There is some risk of injury to the fetus by the procedure. Abortion is, of course, the greatest danger to the fetus. Next in importance is trauma and bleeding from puncture sites. Infections occurring both in the fetus and the mother have been reported. Maternal bleeding and sensitization to fetal blood factors are also serious threats. These can in turn result in fetal problems through the development of maternal antibodies. The dangers must, of course, be weighed against the importance of the information to be gained by amniocentesis.

Spectrophotometric studies of amniotic fluid samples provided some of the first important information about fetal physiology. These analyses are presently used primarily in the management of severe Rh-isoimmunization. Changes in the optical density relate accurately to the severity of the disease. As noted in the 1960's Liley developed a protocol for predicting the degree of fetal red cell destruction based on spectrophotometric changes of amniotic fluid. These findings are plotted on a scale which is usually divided into three zones, the upper zone indicating imminent fetal demise. Neonatal morbidity and mortality are predictable by this method. The need for early delivery, intrauterine transfusion and even later exchange transfusions are also revealed.

Surely the most important advances to come from amniocentesis are in the area of estimating fetal maturity, particularly pulmonary maturity. Prior to the late 1960's fetal maturity was based on such clinical findings as estimates of fetal size, radiographic appearances and the mother's menstrual history.

The majority of cases of neonatal morbidity and mortality are related to pulmonary immaturity. The Respiratory Distress Syndrome (RDS) or hyaline membrane disease affects as many as 50,000 infants per year and approximately one-half of these die. The incidence of RDS is highest in premature infants, infants of diabetic mothers and infants delivered by Caesarean-section.

In the late 1960's and early 1970's Gluck[3] at the University of Southern California, using amniocentesis, began to develop a method of estimating fetal lung maturity. He determined that pulmonary maturity correlates with the ratio of lecithin to sphingomyelin in the amniotic fluid. Lecithin is a phospholipid from the alveolar surface of the fetal lung. The developing lung is a secretory organ; the chief constituents in this regard are lecithin and sphingomyelin. From early gestation until about 30 weeks of pregnancy their concentrations are approximately equal. However around 33-to-34-weeks the level of lecithin abruptly rises and that of sphingomyelin diminishes.

In Gluck's original series he reported that RDS did not develop in any infant in which the amniotic fluid ratio of lecithin to sphingomyelin (L/S) was two-to-one or greater. Innumerable reports since that time have confirmed this fact. The L/S ratio is now an accepted method of measuring fetal lung maturity.

Other biochemical analyses of amniotic fluid are leading to many more indices of fetal maturity. The creatinine level, for example, is a very reliable indicator of renal maturity. The level consistently increases in value through the 36th week to a mean of 2.3mg%. There is no significant elevation beyond 36 weeks. Creatinine levels also correlate well to fetal weight. Weiss[4], using uric acid and creatinine together found almost 100% accuracy in determining fetal maturity.

Fetal cells are desquamated into the amniotic fluid throughout pregnancy. As term approaches more sebaceous cells are found. These cells can be identified with Nile-blue stain. The percentage of fat cells that stain increases with the maturity of the fetus.

When induction is indicated amniocentesis could be done to obtain a "maturity-profile." With this information most cases of neonatal immaturity might be avoided. It may also be indicated when placental insufficiency is suspected. In patients undergoing repeated Caesarean-section, prematurity and RDS are always a danger. With amniocentesis they ought to be avoidable. In mothers with diabetes or other chronic diseases in whom early delivery is considered, such a "maturity-profile" would help determine when delivery could be safely undertaken.

The number of genetic disorders that are detectable by amniocentesis is constantly increasing[5]. As our sophistication in cell culture and chromosome identification improves more of these diseases will be discovered during early pregnancy. Some 50 genetic abnormalities can presently be identified or suspected through amniocentesis. These fall into three main categories:

1. X-linked recessive problems. Here only the sex of the fetus is detectable, not the disease. There are some 30 types of disorders, including Duchenne dystrophy and hemophilia, which are in this category.

Since his graduation from the University of Oklahoma College of Medicine in 1960, Philip J. Maguire, MD, has been certified by the American Board of Obstetrics and Gynecology. He is a member of the American College of Obstetrics and Gynecology and the Oklahoma City Academy of Medicine.

2. Chromosomal aberrations. It is estimated that as many as 20,000 infants are born each year with problems secondary to abnormal chromosomes. The most well-known are the various types of trisomy such as those resulting in Mongolism. Any woman pregnant past the age of 35 years should probably have amniocentesis to rule out trisomy, certainly any past age 40. Around one out of 50 pregnant women over the age of 40 will bear infants with trisomy. In one study of amniotic fluid from 600 patients over age 35 there were 15 chromosomal aberrations found and 4 X-linked diseases suspected.

3. Inborn errors of metabolism. In these cases a search is made for diagnostic clues in enzymes, amino acids, hormones (pregnanetriol), or abnormal metabolic processes. Amniocentesis done in patients suspected of having Tay-Sach's disease will often reveal an increase in hexosaminadase activity. Other diseases such as Hurler's syndrome produce increased mucopolysaccharides. Some of the cerebrosidoses are also detectable.

Amniotic-fluid alpha-fetoprotein levels are a reliable indicator of neural tube defects as discussed by Riley[6] and others. In spina-bifida the alpha-fetoprotein may be 5-to-20-times normal. Elevated creatinine phosphokinase (CPK) levels indicate fetal death inutero.

Amniography obtained by injecting dye into the amniotic sac is being used in many ways today. It is possible to detect fetal anatomic abnormalities, multiple pregnancy, fetal death and abnormal presentation among other things. Uterine tumors and deformities may be found by this method. Since the fetus swallows the amniotic fluid, gastrointestinal defects are sometimes seen as well.

Amniocentesis is clearly established as an important technique and there can be no doubt that it is a permanent part of our growing diagnostic armamentarium. The future of prenatal diagnosis clearly holds great promise for more and exciting advances. □

References

1. Bevis, D. C. : Components of liquor amnii in hemolytic disease of the newborn. Lancet **2:**443, 1950.
2. Liley, A. W. : Liquor amnii analysis in the management of the pregnancy complicated by rhesus sensitization. Am J Obstet Gynec **82:** 359, 1961.
3. Gluck, L. et al : Diagnosis of the respiratory distress syndrome by amniocentesis. Am J Obstet Gynec **109:** 440-445, 1971.
4. Weiss, R. R. et al : Amniotic fluid uric acid and creatinine as measure of fetal maturity. Obstet Gynec **44:** 208-214, 1974.
5. Pernoll, M. L. : Prenatal diagnosis. Obstet Gynec **44:** 773-783, 1974.
6. Riley, H. D. Alpha-fetoprotein and prenatal diagnosis of congenital abnormalities, an editorial. So Med J **69:** 129-130, 1976.

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Impotence — Management With Penile Prosthesis

H. THOMAS SETHNEY, MD
JOHNNY B. ROY, MD

Growing acceptance of the sexual revolution may confront the practitioner with patients openly seeking assistance for impotency. Perhaps new indications for penile prosthetic implants is on the horizon.

INTRODUCTION

Historically, the care of organic impotence has posed a dilemma for the physician and the patient alike. Management of these cases by conservative medical measures has in most instances proved of little benefit. Regrettably, however, past experiences with the surgical approach to this problem likewise have been less than gratifying and often fraught with complications and disappointing results. For these reasons, many physicians have restricted the surgical intervention for organic impotence to only a very select group of patients and only as a final alternative.

This article is a presentation of our experience with penile prosthetic implantation between 1971 and 1976. Our aim is to expand awareness of the changing attitude toward penile implantation which has taken place over the past decade. This renewed interest has been derived from many sources, not least of which is a more acceptable surgical result made possible by technical advances as well as more sophisticated prosthetic appliances. Perhaps it is time we re-evaluate which patients could be candidates for this procedure so that more will benefit from it in the future.

From the Urology Section, Veterans Administration Hospital, Oklahoma City, Oklahoma

METHOD

This report is a retrospective study of 25 penile prosthetic implantations done between March 1971 and February 1976. The primary causes of impotence in the cases studied can be categorized as follows: A) Surgical Trauma (15); B) Accidental Trauma (3); C) Diabetes Mellitus (5); D) Priapism (1); and E) cerebral vascular accident (1). See Table 1. The prosthetic appliances used were the Lash prosthesis in two cases, the Pearman prosthesis in 13 cases, and the Small-Carrion prosthesis in ten cases.

RESULTS

In 20 of 25 patients (80%) a technically satisfactory result was obtained. In four of 25 patients (16%) surgical complications requiring removal of the prostheses occurred. The first complication was a 25-year-old white male veteran who sustained a gunshot wound to the spine in Vietnam with subsequent secondary impotence. In 1971, at another institution, a Pearman prosthesis was implanted with a result that the patient considered less than anticipated, and he requested removal and reimplantation. Following reimplantation of a Small-Carrion prosthesis, he developed a wound infection and urethral stricture which required removal of the prosthesis. The second complication occurred in a 49-year-old black male with impotence secondary to a cerebral vascular accident in 1969. A Pearman prosthesis was implanted in 1972 and subsequently, in 1974, the patient sustained a fracture of the distal one-fourth of the prosthesis from an undetermined cause. Because of the instability of the device, he requested removal. The third complication occurred with a Lash prosthesis which herniated

Pt.—Age	ETIOLOGY	TYPE OF PROSTHESIS	DATE SURGERY	OUTCOME
J.W.—42	D. Mellitus	Pearman	3/31/73	Satisfactory
C.H.—58	Aortic Aneurysmectomy	Pearman	2/25/72	Functioned well, but removed per his request two years later
C.F.—44	Lumbar disc surgery	Pearman	4/28/75	Fair
R.A.—58	Rad. Perineal Prost.	Lash-Loeffler	10/27/71	Removed a year later due to herniation through fascia
R.A.—58	Rad. Perineal Prost.	Pearman	5/18/73	Satisfactory
C.A.—48	D. Mellitus	Lash-Loeffler	6/21/73	Satisfactory
E.N.—56	Rad. Perineal Prost.	Pearman	8/13/73	Satisfactory
Q.H.—26	Lumbar Laminectomy	Pearman	3/4/71	Unhappy with result
C.B.—49	Rad. Perineal Prost.	Pearman	8/3/71	Satisfactory
M.H.—28	T-7 fracture	Pearman	6/27/73	Satisfactory
J.E.—59	Abdo-Perineal Res.	Pearman	6/22/73	Satisfactory
J.J.—59	Rad. Retro. Prost.	Pearman	4/13/73	Fair
C.D.-26	C_{6-7} injury	Pearman	6/22/73	Satisfactory
D.M.—59	Rad. Perineal Prost.	Small-Carrion	11/21/75	Satisfactory
R.W.—53	Pariapism	Small-Carrion	2/21/75	Satisfactory
J.F.—25	Gun-shot wound to spine	Small-Carrion	5/5/75	Prosthesis removed due to infection
L.L.—57	Rad. Perineal Prost.	Small-Carrion	10/1/75	Satisfactory
C.P.—49	Cystectomy	Small-Carrion	10/24/75	Satisfactory
A.L.—49	Cerebro-Vasc. Accid.	Pearman	4/19/72	Prosthesis fractured 3 years later, removed
L.Y.—59	Rad. Perineal Prost.	Pearman	3/31/71	Satisfactory
E.K.—55	Abdo. Perineal Resec.	Small-Carrion	1/16/76	Satisfactory but too early to evaluate
R.B.—55	Rad. Prost.	Small-Carrion	1/21/76	Satisfactory but too early to evaluate
M.B.-48	Diabetes Mellitus	Small-Carrion	2/4/76	Satisfactory but too early to evaluate
R.J.—38	Diabetes Mellitus	Small-Carrion	2/25/76	Prosthesis removed due to infection
G.C.—54	Diabetes Mellitus	Small-Carrion	2/25/76	Satisfactory but too early to evaluate

through the tunica necessitating removal one year following implantation. The patient had been pleased with the prosthesis to that time and requested a reimplantation which took place in May 1973 with a Pearman-type device. The fourth complication was an infection, occurring in a recent Small-Carrion prosthetic implant necessitating its removal in April, 1976.

DISCUSSION

Organic sexual impotence has always been a difficult condition to manage. The process of erection is dependent not only on a competent neurovascular mechanism but also includes significant psychological involvement.[1] However, in clinical practice, the vast majority of impotence encountered can be attributed to psychogenic causes and because of the difficulties in dealing with these complex interactions, it is not surprising that the management of impotence has been perplexing and of limited success.[2]

The surgical approach, utilizing implantation, is by no means a new procedure. Such varied implants as bone and cartilage have been used in past years but with little popularity and very limited success.[3] Actually, it was not until the introduction and refinement of the silicone prosthesis that satisfactory surgical results have been achieved.[1,2] In essence, the pliable silicone prosthesis provides a "crutch" to aid the patient with intromission but in no way simulates a complete erection.

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Since his graduation from Baghdad University College of Medicine in 1962, Johnny B. Roy, MD, has been certified by the American Board of Urology. He is presently Assistant Professor of Urology at the University of Oklahoma Health Sciences Center and Operational Chief, Urology Section at the Veterans Administration Hospital in Oklahoma City. Among his medical affiliations are the American Urological Association, the South Central Section of the American Urological Association, the Oklahoma Urological Association and the Kidney Foundation of Oklahoma.

In our experience the technical results of implantation have been very acceptable. Of the 25 patients implanted, 20 (80%) had experienced a technically satisfactory result with a functioning organ. These data coincide with the experience of others. Gee, et al[4] and Morales et al[5] achieved a 79% and an 80% technical success in their respective series. The complication rate in our series is comparable to the morbidity reported by other authors. As listed in the results portion of this article, we had four complications necessitating prosthesis removal for a 16% complication rate.

From the aforementioned statistics, the feasibility of using prosthetic insertion in the treatment of impotence is apparent. The issue at present does not concern the workability of these devices but in which patient groups their use is indicated. Pearman is of the opinion that patients should have retained normal penile sensation with some semblance of orgasm before insertion is warranted.[6] In opposition, Gee et al[4] describes implantation in patients devoid of penis sensation and/or orgasm and reports very gratifying results. Most authors agree that psychiatric consultation is advisable but overall there tends to be a trend toward more frequent implantations for psychogenic problems. Beheri[1] and Lash[7] have reported very good results in their respective series with implantations for purely psychogenic problems.

In our study, only patients with organic impotence with a normal or nearly normal libido and an earnest desire for sexual gratification, either for themselves or their sexual partners or both, were considered for implantation. At present we have no experience with implantation for psychogenic impotence, however, our present inclination is to perform the procedure on patients with psychologic erectile difficulties. The literature discloses that some individuals with non-organic impotence have had rewarding results with implantation.[1,5] □

REFERENCES

1. Beheri, G. E.: Surgical treatment of impotence. Plastic Reconstr. Surg. **38:**92, 1966.
2. Pearman, R. O.: Treatment of organic impotence by implantation of a penile prosthesis. J. Urol. **97:**716, 1967.
3. Bergman, R. T., Howard, H. A., and Barnes, R. W.: Plastic reconstruction of the penis. J. Urol. **59:**1174, 1948.
4. Gee, W.: The impotent patient: Surgical treatment with penile prosthesis and psychological evaluation. J. Urol. **111:**41, 1974.
5. Morales, P. A., Suarez, J. B., Delgado, J. and Whitehead, E. D.: Penile implant for erectile impotence. J. Urol. **109:**641, 1973.
6. Pearman, R. O.: Insertion of a silastic penile prosthesis for the treatment of organic sexual impotence. J. Urol. **107:**802, 1972.
7. Lash, H.: Silicone implant for impotence. J. Urol. **100:**709, 1968.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all inds of scrutiny. Your control over patient therapy is eing monitored, judged and occasionally abrogated, ometimes by unknown third parties.

The worry is that in the wake of this focus, the relaonship between you and your patient will be weakened, ithout offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, gulations or professional custom stipulate that your n-generic prescriptions be filled with the precise prodts you prescribe. But in the last five years, a dozen or ore State laws have been changed, permitting the pharacist in most cases to select a product of the same neric drug to fill any prescription.

Ironically, this dilution of physician control has ken place against a background of growing evidence at purportedly equivalent drug products may be inuivalent, since neither present drug standards nor their forcement are optimal. In fact, the FDA itself says it s not enforced the same standards for hundreds of llow-on" products that it had applied to the original DA approvals. Thus physician control over patient erapy is being eroded with a risk that patients may be posed to drugs of uncertain quality.

The major advertised claim for substitution is reduced escription prices for consumers. Yet no documentation any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is ederal regulation designed to cut the Government's ig bill by setting price ceilings for drugs dispensed to edicare and Medicaid patients. Unless the prescriber tifies on the prescription that a particular product is edically necessary, the Government intends to pay only the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

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Pharmaceutical Manufacturers Association
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PEDIATRIC GRAND ROUNDS

"Tetralogy of Fallot"

W. M. THOMPSON, JR., MD
PROFESSOR OF PEDIATRICS

AL CARTAYA, MD
INTERN, PEDIATRICS

J. J. VANHOUTTE, MD
PROFESSOR OF RADIOLOGY

G. R. WILLIAMS, MD
PROFESSOR OF SURGERY

Doctor Thompson: Today we are going to discuss the most common form of cyanotic congenital heart disease: tetralogy of Fallot. Doctor Cartaya will present the case. Doctor Vanhoutte did the radiological study on this child. I will discuss diagnosis and the clinical picture. Doctor Williams will discuss surgical management.

Doctor Cartaya: The patient was a two-year-old white girl with a heart murmur known since she was seven weeks of age; she was asymptomatic at that time. By four months of age the child was said to have generalized hypercyanotic spells, especially when crying. The diagnosis of tetralogy of Fallot was confirmed by cardiac catheterization performed when the child was at 14 months of age. Subsequently a right Blalock-Taussig anastomosis was performed. The postoperative course was benign and there was a subsequent decrease in hypercyanotic spells. Definitive surgical repair of the cardiac defect and takedown of the Blalock shunt was done March 1, 1972, while the patient was on cardiopulmonary bypass. She had transient postoperative edema and azotemia which was thought to be secondary to inappropriate antidiuretic hormone (ADH) secretion and slight underhydration. She was discharged 11 days postoperatively (March 12) in satisfactory condition except for some persistent edema and a slight cough. At the time of discharge she was afebrile. Twenty-four hours after discharge, however, the child developed fever, progressive grunting respiration, dyspnea, and cough, and consequently was readmitted with the initial impression of postpericardiotomy syndrome. Physical examination revealed a pale, slightly dyspneic girl with minimal circumoral cyanosis and a cough. Respiration rate was 42/min, and heart rate was 120 to 130/min. Examination of head, ears, eyes, nose, and throat was unremarkable except for the presence of inflamed gingiva. There was a healing, midsternal, Y-shaped incision over the chest. Inspiratory rales were heard at the bases of both lungs, but primarily on the left. There was a grade IV/VI stystolic murmur heard over

From the Department of Pediatrics, The Children's Memorial Hospital, University of Oklahoma Health Sciences Center and The Oklahoma Department of Institutions, Social and Rehabilitative Services.



Fig 1. Roentgenogram at two months of age suggesting diagnosis of tetralogy of Fallot.

the entire precordium. Point of maximal impulse (PMI) was slightly shifted to the midaxillary line, and no rub was heard.

First and second heart sounds were muffled. The liver was thought to be depressed four cm; the spleen was not palpated. There was no clubbing or cyanosis of the extremities, but there was 2+ to 3+ pitting edema. Neurologic findings were within normal limits. Roentgenograms revealed a slight increase in cardiac size, with indistinct apex and prominent pulmonary vascularity. Laboratory data revealed the hematocrit was 32.2%, WBC was 8,700/cu mm (no differential given), and the urine was normal. On the day after admission, a friction rub compatible with postpericardiotomy syndrome was heard over the precordium. Treatment consisted of bed rest and the administration of aspirin. The patient was discharged five days after admission. Two follow-up examinations in the OPD revealed gradual improvement in her condition. She is being maintained on digoxin (Lanoxin), 0.1 mg twice a day.

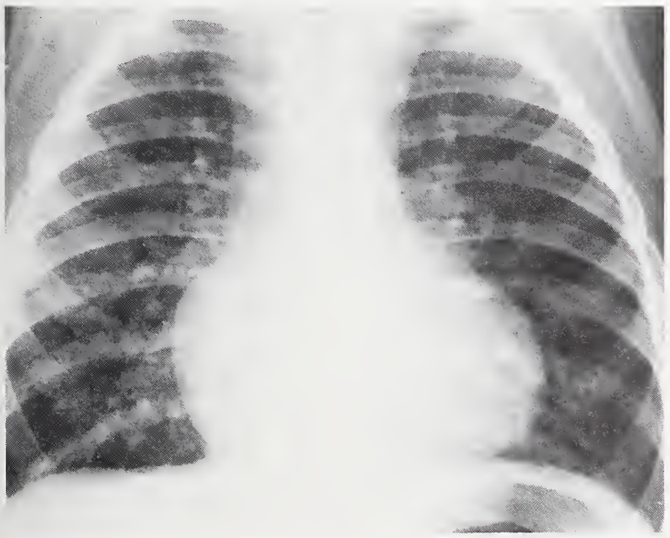


Fig 2. Roentgenogram at 15 months of age, six weeks after Blalock-Taussig anastomosis on right side.

Doctor Vanhoutte: Figure 1 is a reproduction of the first roentgenogram of the chest that we have on this child. The child was two months old. The lungs are clear, slightly hyperexpanded, and marginally perfused. The overall size of the cardio-mediastinal outline is well within normal limits. The apex of the heart, however, appears a little elevated. This suggests right ventricular hypertrophy. Combined with the clinical observation of cyanosis, these findings suggest the diagnosis of tetralogy of Fallot. It is not at all unusual not to see the "boot-shaped" heart at this early age.

At the time the roentgenogram of the chest reproduced in Figure 2 was obtained, the patient was 15 months old. Six weeks before, she had undergone a Blalock-Taussig anastomosis on the right side. Because of this anastomosis, the pulmonary perfusion has improved. The slight elevation of the cardiac apex persists. The heart size remains normal.

An angiocardiogram was obtained when the patient was 29 years old. Via the superior vena cava, the injection of contrast agent was made in the right ventricle. On the frontal projection (Fig 3A), during cardiac systole the right ventricle outflow is exceedingly narrow. This is followed by a small infundibular chamber, sometimes referred to as a third ventricle. The main pulmonary artery is not well seen on this projection. On the lateral projection (Fig 3B) it is well-demonstrated and appears hypoplastic. This patient, therefore, has at least two levels of obstruction to the right ventricular outflow. Multiple levels of obstruction are not uncommon in tetralogy of Fallot. Incidentally, a small amount of contrast agent can be seen in the aorta. It reached this locale by crossing the ventricular septal defect.

At the age of 32 months (Fig 4), just prior to total correction, the patient's pulmonary perfusion has again become marginal. The apparent slight increase in the heart size and the apparent lesser elevation of the cardiac apex are the result of a shallower inspiration, rather than a true change in the heart.

One week after total correction (Fig 5), the pulmonary perfusion is similar to what it was after the Blalock-Taussig anastomosis (Fig 2). The heart is slightly larger than it was preoperatively (Fig 4). This slight increase in cardiac size is not unexpected shortly after a total correction.



Fig 3A

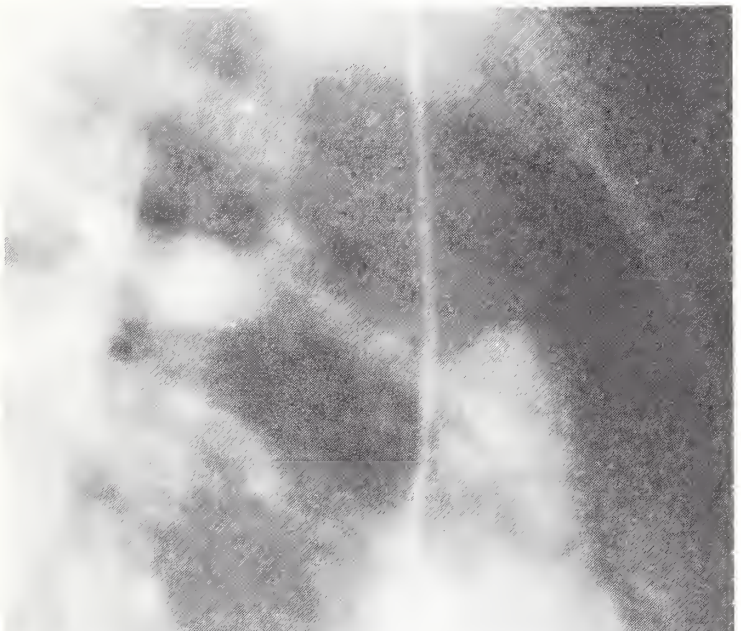


Fig 3B Angiocardiogram at 29 months, anteroposterior view (A) and lateral view (B).

Twenty-four days after the total correction (Fig 6), the cardiac outline has increased rather remarkably. The configuration assumed



Fig 4. Roentgenogram at 32 months, just before total correction.

by the cardiac silhouette on this reproduction is suggestive of pericardial effusion. The typical picture of pericardial effusion is altered in this case by postoperative adhesions between the pericardium, the pleura, and the anterior chest wall. At this time, minimal thickening of the inter-lobar fissures was the only evidence of pleural effusion. Six weeks after the surgical correction (Fig 7), the cardiac outline is well on its way to assuming a normal configuration.

In summary, I have shown the classical evolution of the roentgenographic findings in tetralogy of Fallot. A relatively benign form of the "post-pericardiotomy syndrome" was the only complication this child had.

Doctor Thompson: This child did have the combination of abnormalities usually referred to as tetralogy of Fallot. We will go into some detail in this discussion because of the fre-

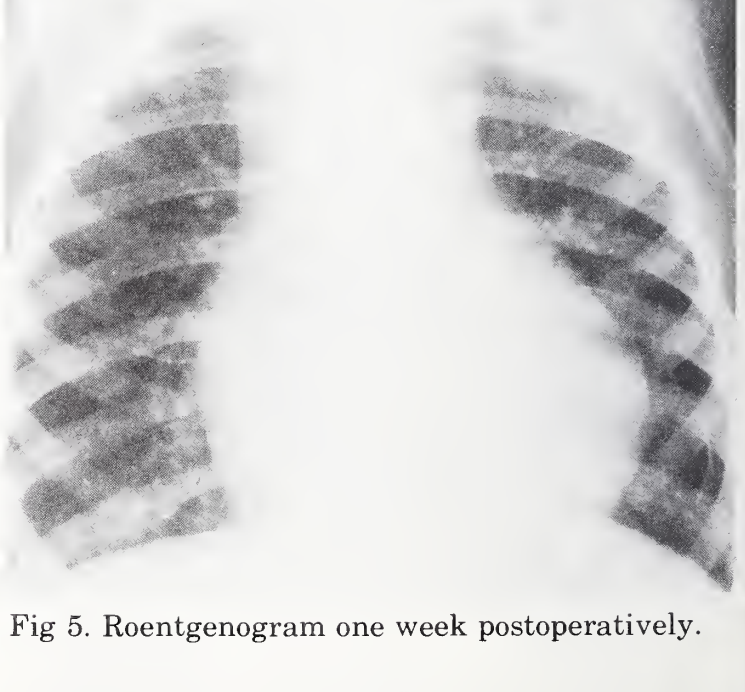


Fig 5. Roentgenogram one week postoperatively.

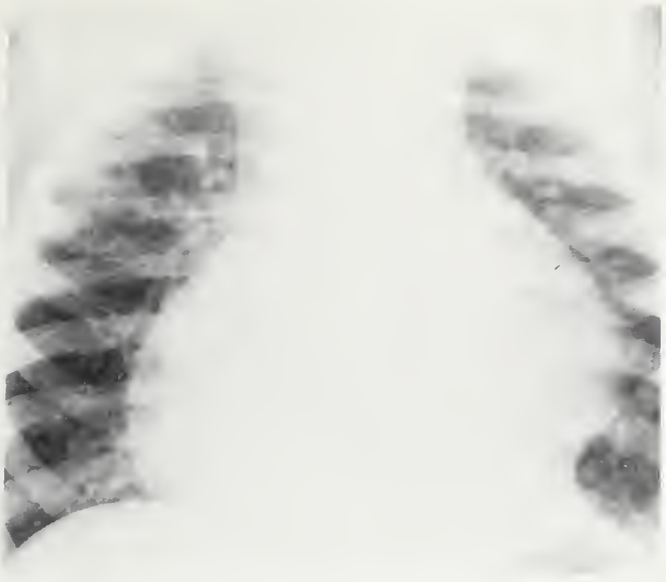


Fig 6. Roentgenogram 24 days postoperatively.

quency with which this particular group of abnormalities occurs. The basic difficulty in this situation, the combination of pulmonary stenosis and ventricular septal defect, was described by Stenson approximately 300 years ago. Fallot, in 1888, defined the syndrome as a combination of these two defects plus dextroposition of the aorta and right ventricular hypertrophy. The description of Fallot enabled the clinical diagnosis to be made. However, Doctor Taussig placed the clinical recognition on firm ground in the 1930s.

The syndrome makes up approximately 15% of the congenital heart disease seen in all children over two years of age. If you consider all the children born with it, it is responsible for 10% of congenital heart disease cases. In patients over a year of age who are cyanotic, 50% to 75% will have this particular syndrome, since most of the children with other cyanotic



Fig 7. Roentgenogram six weeks postoperatively.

abnormalities do not survive their first year unaided by surgery. The cause is unknown, as it is in most cases of congenital heart disease. It is known, however, that there is a higher incidence of patients with tetralogy of Fallot with increasing maternal age. The reported sex incidence varies somewhat; most give a 6:4 ratio of males to females. From an embryologic viewpoint, the malformation is best explained by maldevelopment of the bulbus cordis, the structure from which the outflor tract of the right ventricle is derived, and which contributes to formation of the membranous portion of the ventriculum septum. Defects in the development of the bulbus cordis occur between the fifth and seventh weeks of intrauterine life, implying that the insult causing this syndrome occurs during that period. The anatomy of the defect is interesting and quite variable. Classically, as described by Fallot, it includes a ventricular septal defect, pulmonary stenosis, dextroposition of the aortic root, and right ventricular hypertrophy. The conclusion that this particular combination gives rise to the same clinical picture in all cases is not tenable. Modern means of studying cardiac function in the intact human being bring this out sharply.

Individually, the component parts of the abnormality are important and are quite interesting. In patients with tetralogy of Fallot, the ventricular septum is always patent; the ventricular defect is usually large (one to three cm in diameter), including virtual absence of the membranous portion of the ventricular septum. It is located in the membranous portion of the septum with close relationship to the septal leaf of the tricuspid valve and to the aortic root.

Normally, there is a very close spatial relationship of the membranous septum to the aortic valve, which lies in the lowest of the semi-lunar valves and appears to straddle the ventricular septum. Perforation of the membranous portion of the ventricular septum in a normal individual will give the appearance of aortic overriding. Actual malposition of the aorta is probably relatively uncommon in tetralogy of Fallot. The superior margin of the defect from the left ventricular side would be contiguous with the right or posterior aortic cusp. The lower border usually is made up of the muscular portion of the septum. It is thick, saddle-shaped, and is, of course, near the common conduction system, the bundle of His. I am

sure Doctor Williams will comment on this relationship.

The pulmonary stenosis, which is also a consistent anatomic anomaly in tetralogy of Fallot, is more variable than is the septal defect. The narrowing may involve the infundibulum; it may involve the valve; it may involve both and may be supervalvular in site. There is almost always hypertrophy of the crista supraventricularis, which may produce further stenosis on a functional basis. Complete atresia of the outflow tract is not uncommon and will occur in approximately 20% of all cases. The site of stenosis varies sharply between autopsy and operative cases, but in approximately 50% of patients with tetralogy of Fallot the stenosis will be subvalvular alone; in another 20% to 25%, it will be a combination of valvular and subvalvular. Distal pulmonary stenosis also occurs.

Dextroposition of the aorta probably is not really present. It is certainly of little physiologic significance and has little or no prognostic importance. The amount of this is difficult or even impossible to quantify at autopsy, and as mentioned, does not necessarily imply an abnormal position of the aortic root. It is of surgical importance since damage to the aortic valve can occur in repair of any ventricular septal defect.

Right ventricular hypertrophy is a secondary phenomenon present in all patients who have pulmonary stenosis. It is of little clinical or physiologic importance, except that it may contribute to the degree of obstruction because of hypertrophy of the outflow tract area.

The development of the left ventricle in some very severe cases may be abnormal. This, however, usually is not a significant clinical problem. In the majority of cases the thickness of the left ventricular wall is equal to that of the right ventricle. There is sometimes variation in the chamber volume, but in approximately 50% of the cases the chambers are equal in size.

Other anatomic variations are of interest. The atria usually will show little change, although the right atrium may show mild hypertrophy. Patency of the atrial septum is rare in some series, more common in others, but usually is of no functional significance. The importance of recognition for surgical correction is obvious. Enlargement of the aorta is usually seen, and is a function of the degree of the right-to-left shunt; the larger aortas are found in those patients in whom the shunt is greatest. Approximately 20% to 30% of patients with tetralogy of Fallot will have a right-sided aortic arch. A right-sided aortic arch occurs with such frequency in only one other congenital abnormality: truncus arteriosus. The presence of a right-sided arch is frequently a clue to the particular diagnosis. Collateral pathways for pulmonary blood flow are increased; the most common example is persistent patency of the ductus arteriosus. This has been reported to occur in 20% to 25% of the patients with this abnormality. Although this complicates the situation, chances for survival are more favorable. Dilated bronchial collaterals occur very frequently. They are more severe in extreme cases and are a function of age, being noted in the older patients more often than in the younger ones. Noncardiac abnormalities occur in approximately 20% of patients with tetralogy of Fallot. These are most commonly renal abnormalities of some type.

The physiology of the combination of abnormalities is almost as variable as the anatomy. From a functional viewpoint, the essential components of the abnormality are the presence of the ventricular septal defect and pulmonary stenosis. Obviously, the spectrum can be quite wide, depending on the relative severity of these two lesions. With very small ventricular septal defects, function is essentially the same as in persons with an intact septum. In the typical tetralogy the defect is large, so that there is no gradient in pressure across the defect; the two ventricles function with a common ejectile force and with equal pressures. The pathophysiology is thus dependent upon the degree of pulmonary stenosis. In patients with little pulmonary stenosis, the clinical picture is similar to that of any other patient with a large left-to-right shunt. This grades all the way down to those with complete pulmonary atresia and a total right-to-left shunt at the ventricular level. The clinical picture, of course, will vary. It should be remembered that in all patients in whom the pulmonary stenosis is severe enough so that there is no shunt, or a right-to-left shunt, the total cardiac output is normal. The right ventricular pressure load can never exceed that on the systemic side. Thus, cardiac size is not increased and cardiac decompensation does not occur on the basis of the anatomic abnormality.

In the cyanotic patient the pulmonary blood flow is fixed, since the right ventricular pres-

sure can never exceed the systemic pressure, and thus cannot rise to produce a greater flow through the stenotic area. It is more likely that the degree of pulmonary stenosis will actually increase rather than decrease. In these patients, pulmonary blood flow is maximal and any significant change in venous return is usually associated with changes in the volume of the shunt across the ventricular septum rather than with any significant change in pulmonary blood flow. The pulmonary blood flow is decreased, with a corresponding decrease in the size of the pulmonary vessels. Under the circumstances and with peripheral vasodilation, there will also be an increase in the right-to-left shunt.

The most striking clinical finding in these patients is cyanosis. This is strictly a function of the degree of pulmonary stenosis and adequacy of the diet, and not of the position of the aorta. The onset of cyanosis with tetralogy of Fallot is extremely variable. Approximately one-third of these patients are cyanotic from birth. Another one-third become cyanotic during the first year of life. The remainder may not become cyanotic until the early teen years. The degree of cyanosis varies in the same patient; it varies even more from one patient to another. There is a tendency, however, for it to become more severe with increasing age, size and activity. None of these patients are really asymptomatic. Most of them have a tendency to squat with activity, at least early in life, and they are almost invariably dyspneic with exertion. A history of hypercyanotic spells is obtained frequently, as is the case in this particular child. These episodes may produce unconsciousness, convulsions, and death. They are an indication of the severity of the abnormality. Their occurrence is an indication for early surgical intervention.

On physical examination, these patients are cyanotic. The cyanosis is central in type and involves the lips, mucous membranes and nail beds. It is frequently associated with suffusion of the conjunction, a malar flush and, not uncommonly, clubbing of the nose. Physical development in these patients is often retarded, although not necessarily so. Poor muscular development is almost certain. There is no precordial bulge, the precordial activity is normal, and clinically, cardiomegaly is not present. Cardiac findings include a systolic ejection murmur over the outflow tract and pulmonary valve area; it is a murmur of pulmonary stenosis. There may be a thrill and, usually, a relatively pure basal second sound. The degree of obstruction obviously affects the murmur, as in other patients with pulmonary stenosis, and the murmur is completely absent in those who have pulmonary atresia. With the presence of ductus arteriosus, or very marked development of the bronchial collateral patency vessels, or both, continuous murmurs are common. The murmur of the blood flow will be noted over the typical area. An increase in anteroposterior diameter of the chest is fairly common. There usually is no evidence of venous engorgement or anything else to suggest heart failure. The electrocardiogram will show evidence of right axis deviation and unless right ventricular hypertrophy is quite severe, there usually is no evidence of atrial hypertrophy. In patients with the same degree of pulmonary stenosis with an intact septum, evidence of right atrial hypertrophy is usually seen.

Doctor Vanhoutte has commented on the radiograph picture of this abnormality. I would like to emphasize again that right-sided aortic arches occur fairly often with this abnormality, and with pure tetralogy of Fallot, cardiac enlargement is not part of the picture.

Cardiac catheterization in these patients is of little help. It will reveal evidence of right ventricular hypertension at systemic levels. There usually is a very slight left-to-right shunt at the ventricular level, and of course, a right-to-left shunt will be present. There will be a gradient across the outflow tract with normal pulmonary arterial pressures. Peripheral arterial unsaturation will be present. The catheter frequently can be manipulated across the ventricular septal defect and into the ascending aorta. Selective angiocardiography, as noted, will reveal simultaneous filling of both the pulmonary artery and the aorta, and will reveal details of the anatomy as shown by Doctor Vanhoutte.

Prognosis in patients with tetralogy is variable. Rather remarkable longevity has been reported on occasion, with survival up to the fifth and sixth decades. Most patients, however, do not survive the teenage period. The signs and symptoms and prognosis, unaltered by surgical intervention, vary with the degree of pulmonary stenosis.

Patients with tetralogy of Fallot are usually grouped into three categories. Group 1 comprises the most severe forms of the disease, and includes the patients with pulmonary atresia. These patients are cyanotic from birth. Not uncommonly they are dependent upon the ductus

arteriosus or bronchial collaterals or both for the major portion of their pulmonary blood flow. Cyanosis, however, is quite severe. Almost always the hypercyanotic spells begin to occur at the age of three or four months and usually increase in frequency and severity. Unless these patients are operated upon, they rarely survive the first year of life. Death usually occurs with a major hypoxic spell. If they survive the first year on collateral flow, they may live for several years, but they are markedly cyanotic and severely disabled. They seldom survive the second decade of life. In this group of patients, squatting is rare. They are usually very irritable, but mentally alert.

Group 2 patients are considered the most typical of this particular combination of abnormalities. They have the murmur and are cyanotic, although not as severely. Hypoxic spells begin around six months of age, but they occur less frequently and with less severity than in Group 1. These children are also very irritable, intolerant of exercise, and usually mentally alert. A loud systolic ejection murmur and thrill are present over the precordium. They do not tolerate extremes in temperature. Symptoms become more severe as the children grow older and become more active. Their difference from other children, which grows more marked, becomes a major problem both for the child and for the parents. Survival into the second decade of life is common. Rarely, survival into the third decade occurs. They usually meet their demise in trying to cope with the stresses of adolescence. Death in these patients is associated with hypoxic episodes, cerebral accidents, brain absecces, and endocarditis. Congestive heart failure can be seen in patients with severe anemia or with endocarditis, particularly if they develop aortic regurgitation.

As mentioned, both of these groups of patients have episodes that are usually referred to as hypercyanotic spells or blue spells. The spells tend to occur after exercise, after feedings, or upon arising in the morning. Many theories as to the cause have been put forth. These include episodes of spasm of the outflow tract resulting in an increase in the degree of cyanosis. The efficacy of morphine in treating spells was postulated as due to the effect of decreasing myocardial contractility, thus decreasing the degree of pulmonary stenosis. Studies have shown, however, that morphine given in doses that are effective increase myocardial contractility and, if anything, actually increase the degree of obstruction. The most logical explanation of these episodes is that they are related to hyperpnea. In these patients, for one reason or another, the right-to-left shunt increases and arterial oxygen saturation decreases. The normal response to this is an increase in the rate and depth of respiration. In normal persons, this results in an increase in the degree of oxygenation of the blood. This cannot occur in patients with tetralogy of Fallot, since their pulmonary blood flow and oxygenation are maximal at all times. Thus, with an increase in hyperpnea and breathing effort, more oxygen is consumed. Arterial saturation drops further, and a vicious cycle is set up that eventually results in unconsciouness and convulsions. The treatment in these patients is the administration of morphine, because of its depressant effect on respiratory activity. In contrast to what occurs in a normal person when morphine is given in respiratory-suppressant dosages, the arterial saturation in these patients rises rather than drops. In addition, since an increase in the venous return produces a greater right-to-left shunt, decreasing the venous return in these patients tends to improve the arterial saturation. The immediate tendency of almost all concerned with the care of these patients is to administer oxygen. Fortunately, as long as the oxygen is cool, it will do no harm.

The Group 3 patients are those with the so-called pink tetralogy or atypical tetralogy. These patients have a lesser degree of pulmonary stenosis without a gross right-to-left shunt with cyanosis. These patients commonly survive into the third or fourth decades of life, although rarely beyond age 40. The treatment of this particular condition, as of most other types of structural abnormalities of the heart, is surgical.

There are many types of procedures employed for correction of this abnormality. Careful consideration of the physiology of this abnormality leads to the concept of partial physiologic correction, resulting in amelioration of the abnormality rather than complete correction. The historical importance of this particular procedure is tremendous, because its success led to the development of the whole field of cardiac surgery and pediatric cardiology.

In the adult patient with tetralogy of Fallot

there usually are marked fibrotic changes in the outflow tract, which further increase the difficulty of total correction. Proper management of the adult case is not well documented.

Complications become more frequent with advancing patient age. The incidence of cerebral abscesses in these patients is high, as it is in any patient with cyanotic abnormalities. Such abscesses are rare before the age of two. They frequently follow a respiratory tract infection; symptoms at onset are headache, vomiting, personality changes, and focal neurologic findings. Fever may or may not be present, but usually is. It is important to remember this greater frequency, since the diagnosis is difficult. The importance of making an accurate diagnosis and undertaking proper treatment is obvious. Polycythemia, and the resulting increase in blood viscosity, is of importance. With polycythemia, bleeding and clotting problems become significant, presumably on the basis of a consumption coagulopathy. This is a phenomenon based on time, becoming of increasing incidence and severity with advancing age. Bacterial endocarditis, another significant danger, probably occurs more frequently in patients with tetralogy of Fallot than it does in almost any other congenital anomaly of the heart. Hemoptysis is common in the older patients due to rupture of extensive collateral vessels in the lung; it also can be associated with thrombosis and pulmonary infarction. Gastrointestinal bleeding, probably due to thrombocytopenia, can occur. Gout does occur in the older patient; I am not familiar with reported cases in children. Tetralogy of Fallot may protect individuals from the complication of coronary heart disease, since in the patients that survive into adulthood, huge coronary arteries are seen that are not significantly involved with atherosclerosis. Perhaps the alternative is worse than the disease that is cured.

Doctor Williams will now comment on the surgical management.

Doctor Williams: The tetralogy of Fallot is interesting to surgeons for several reasons. Foremost, it is a common and disabling abnormality. Doctor Thompson has given the incidence figures. A second reason for interest is that very effective surgical treatment has been developed within a relatively short period of time, and it now seems possible to restore these incapacitated children to a near-normal life expectancy in the majority of instances. A final reason is the considerable historic interest in this form of congenital heart disease.

The first successful operation for congenital heart disease was the successful ligation of a patent ductus arteriosus in 1939 by Dr. Gross. This was a significant surgical achievement, but perhaps because the child with patent ductus really does not appear to be sick, it did not attract a tremendous amount of attention. The introduction of a procedure which dramatically changes a scrawny cyanotic baby to a pink, normal-looking child, however, did generate world-wide attention, and I believe this was the greatest stimulus for the interest in cardiovascular surgery that has resulted in enormous progress in the three decades since Doctor Blalock's operation. Doctor Alford Blalock was a young surgeon who had come from Vanderbilt to be Chief of Surgery of the Johns Hopkins Hospital. Principally interested in the surgical laboratory and in surgical physiology, Doctor Blalock had developed in the dog lab a method of producing pulmonary hypertension by anastomosing a brachiocephalic artery to the pulmonary artery. This was a nice operation, but it did not produce pulmonary hypertension and was a failure as far as Doctor Blalock was concerned. Doctor Helen Taussig became interested in the heart while she was a medical student in Boston. After graduation, she came to Johns Hopkins to work in the Department of Pediatrics under Doctor Edwards Park. Doctor Taussig did for pediatric cardiology what Doctor Maud Abbott had done for the pathology of congenital cardiac lesions some decades before. She systematically attempted to make an accurate diagnosis and to categorize both the physical findings and the physiologic effects in the various forms of congenital heart disease. In the process, it occurred to Doctor Taussig that a method of surgically improving pulmonary blood flow ought to greatly improve children with tetralogy of Fallot. She mentioned this to Doctor Blalock, who thought of his experiments attempting to produce pulmonary hypertension. The two of them decided that this could and should be tried in children. The first operation was performed. The procedure went very well and the child became pink. Interest and enthusiasm rapidly diffused throughout the institution and, although the early experience was difficult and the mortality rate high, the saving of these infants started a distinct trend.

Today, proper management of the tetralogy

depends on the age at which the child becomes symptomatic. In the 30% of patients with tetralogy of Fallot who become significantly symptomatic and begin to have hypercyanotic spells in early life, we feel that palliative procedures are still the operations of choice. There is an arbitrary dividing line at three years of age. If children have to have something done before three years of age, we recommend a palliative operation.

Palliative operations for tetralogy at the present time are four in number. The oldest of the palliative operations is the Blalock-Taussig procedure, in which the subclavian artery on the side opposite the arch is simply divided and the proximal end of the subclavian artery brought down and attached by vascular anastomosis to the side of the pulmonary artery. This perfuses both lungs with systemic unsaturated blood. It is not an easy operation, but it has now been done in large numbers and produces very satisfactory palliation in the majority of patients in which it is carried out successfully. The operation does not work very well in the small infant, because the structures are so small that an appropriate anastomosis which will remain patent is difficult or impossible to construct.

Not long after Doctor Blalock's operation was described, Doctor Willis Potts in Chicago described a procedure that could be applied more successfully in infants. The second operation, known as the Potts procedure, is a direct anastomosis between the descending thoracic aorta and the side of the left main pulmonary artery. Where the left main pulmonary artery crosses the aortic arch, it is possible, using a set of special instruments, to make a longitudinal anastomosis between the two. It is technically simpler than the Blalock procedure, and it has the great advantage of being applicable to infants. Its disadvantage, however, is that it is extremely difficult to take down at a later date when total correction is done, and this difficulty has led to the virtual abandonment of the Potts operation. What most surgeons do now when shunting is indicated was described by David Waterston at Great Armond Street Hospital a number of years ago and is known as the Waterston operation. It consists of an anastomosis between the ascending aortic arch and the right main pulmonary artery behind the aorta. This operation is also known by a number of other surgeons' names (Cooley) and has the great advantage of being very simple to correct at later repair of the defect.

The fourth operation that can be done in the infant that requires palliation is the so-called Brock operation, in which a blind attempt at opening the stenotic pulmonary outflow tract is performed. I mention it because there are two or three centers in the United States in which it is done. We have not used this procedure in a tetralogy here.

In all children, whether they required a palliative operation before age three or not, we think that correction of the tetralogy of Fallot should be carried out before they enter school. The operation is technically as easy at that time as any other. The adjustment problems are somewhat less and, actually, the procedure seems easier on the child at that age than it does if the child is not operated on until a later age. The correction of the tetralogy of Fallot is carried out with the patient on cardiopulmonary bypass. The operation has two components: the first problem is to close the ventricular septal defect, and the second is to relieve pulmonary stenosis. The ventricular septal defect of the tetralogy of Fallot is anatomically different from any other ventricular septal defect, and it is a little harder to close. The other concern with closure of the ventricular septal defect is the section of the bundle of His. The conduction bundle passes close to the ventricular septal defect. Since there is, as yet, no reliable method of detecting the presence of the bundle, the production of complete heart block during closure of this ventricular septal defect is always a possibility, and one which has dire consequences for the patient. The second part of the problem is opening the pulmonary outflow tract. Variations in the anatomy of the outflow tract are common. Stenosis may be infundibular, valvular, or both. Opening the valve is extremely simple, but often infundibular stenosis requires a fairly complicated dissection of the musculature of the outflow tract of the right ventricle. When results of the operation to correct the tetralogy are poor, the most common cause by far is failure to completely relieve the ventricular outflow obstruction.

Multiple postoperative problems may follow correction of the tetralogy of Fallot. These include the bleeding abnormalities that are a threat in any cyanotic patient. Of course, such problems are somewhat magnified by the fact

that one does have to suspend the clotting systems of patients who go on cardiopulmonary bypass. Heart block may require the use of a pacemaker. Postoperative bleeding not related to clotting difficulties is a problem because of extensive collateral vessels. Finally, failure to adequately perform the two mechanical parts of the procedure, that is, closure of the ventricular septal defect and relief of pulmonary stenosis, adds to postoperative problems.

The mortality for tetralogy of Fallot repair was very high all through the 1950s and even into the early 1960s. The mortality now is below 10%. The percentage of satisfactory anatomic and physiologic corrections probably exceeds 85%, and it looks as if these recovered children will live relatively normal lives.

Somebody is going to ask about the postpericardiotomy syndrome this child presented. This is an as-yet-unexplained phenomenon that can occur after any procedure in which the pericardial cavity is opened. It consists of fever, splenomegaly, splinter hemorrhages, and pericardial effusion or at least pericardial friction rubs. The only nice thing about it is that it goes away with the use of salicylates. We do not know the cause. It is not common after surgery for the tetralogy of Fallot; surprisingly it is most common after closure of an atrial septal defect.

Repair of the tetralogy of Fallot is one of our more successful areas in surgery. It does restore these children, with a life expectancy of a decade and one half at best, to what we think will probably be a normal life span.

Doctor Seely: I want to ask Doctor Williams about the duration of follow-up available on a reasonable number of children and about their growth.

Doctor Williams: The first total corrections of tetralogy of Fallot were performed in 1954. No one has very many cases and even fewer survivors for about the subsequent five years. So, at the present time, we are talking about a 12-year follow-up in any appreciable number of patients. I cannot give you the figures in relation to growth; perhaps Doctor Thompson can. Most of the children grow at a normal rate, granted that they started low on the scale.

Doctor Thompson: Statistically, most of the children are smaller than other children of their age and at the same degree of development. There are a significant number of patients who do have a growth spurt. Most, as Doctor Williams mentioned, never reach normal size, but they grow at an essentially normal rate after the operation. Apparently they lose much of their growth potential in the first year or so of life, before correction, and never really catch up. Frequently, these patients have been classified as having a significant central nervous system problem with low intelligence because of the cyanosis and cerebral hypoxia. In general, this is not severe and I doubt the accuracy of the previous classification. There is a tendency to operate, with the idea that they may be able to achieve more potential of total growth and development. This is true regardless of the abnormality you are dealing with. It is of interest to note that nobody commented on the place of digitalis in the treatment of these patients. They do not require digitalis prior to surgery, but most of these patients show very poor right ventricular function for 12-to-18-months postoperatively. For this reason, we usually digitalize all tetralogy of Fallot patients after the operative procedure. □

ANNOUNCEMENT

Application for Research Grants-in-Aid and for Postdoctoral Research Fellowships, for the year beginning July 1st, 1977, are now being accepted by the American Heart Association, Oklahoma Affiliate, for review by the Research Policy Committee.

Application forms may be obtained from the American Heart Association, Oklahoma Affiliate, Inc., 800 N.E. 15th Street, P.O. Box 11376, Oklahoma City, Oklahoma 73111. These applications must be received or postmarked no later than **November 1st, 1976.**

News From The Oklahoma State Department of Health

State-Wide A/New Jersey Immunization Program

The first shipment of both bivalent and monovalent influenza vaccines is expected the first week in October. The exact amount of vaccine is unknown but hopefully the bivalent vaccine for the high risk population will be supplied in sufficient amounts that all health providers will receive enough vaccine to begin Phase I of the statewide program.

Physicians who wish to participate in the program will receive the vaccine from local county coordinators. The Congress has passed legislation providing liability protection to all participants in the national program who provide the vaccine without charge for such vaccine *or its administration*. It is important to point out that both the bivalent and monovalent vaccines will be FDA approved biologics similar to flu vaccines used in past years and will carry no additional risk than the flu vaccines of the past. Physicians administering the vaccines who elect to charge an administration fee must realize that their personal professional liability insurance must be operative in the event some individual seeks damages as a result of the vaccination administered in the private office setting when an administration fee was charged.

Physicians who provide influenza vaccine to their patients with or without administration fee are not required to obtain written informed consent signatures from their patients on the registration form. We would recommend that all recipients provide written informed consent on the registration sheet but *this is not a requirement* when vaccine is administered in the "usual private physician-patient relationship." The demographic data (name, age, sex, race, county of residence) on the registration sheet must be supplied whether or not the signature is requested by the physician. Questions regarding the program should be directed to the County Coordinator or the State Department of Health Influenza Project. Phone 405 271-5603. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR AUGUST, 1976

DISEASE	August 1976	August 1975	July 1976	Total To Date 1976	1975
Amebiasis	—	6	3	8	22
Brucellosis	—	—	4	7	3
Chickenpox	9	6	42	1565	950
Encephalitis, Infectious	2	—	2	14	33
Gonorrhea (Use Form ODH-228)	1259	1324	1297	8755	8578
Hepatitis, A, B, Unspecified	57	40	90	962	536
Leptospirosis	—	—	1	1	—
Malaria	1	—	1	2	1
Meningococcal Infections	1	—	—	19	9
Meningitis, Aseptic	7	12	2	18	46
Mumps	20	10	21	668	182
Rabies in Animals	11	5	7	101	76
Rheumatic Fever	1	—	2	11	7
Rocky Mountain Spotted Fever	15	5	33	80	72
Rubella	6	3	6	60	83
Rubella, Congenital Syndrome	—	—	—	—	1
Rubeola	2	—	5	288	126
Salmonellosis	29	41	42	165	133
Shigellosis	10	42	9	152	235
Syphilis, Infectious (Use Form ODH-228)	7	12	12	77	59
Tetanus	—	—	—	—	—
Tuberculosis, New Active	29	29	32	236	217
Tularemia	—	3	1	7	9
Typhoid Fever	1	—	—	1	—
Whooping Cough	8	2	5	18	21

For Consultation Call: (405) 271-4060

OKLAHOMA'S HOSPITALS: A STORY OF CHANGE

With Cleveland Rodgers, Executive Director, Oklahoma Hospital Association

By Richard L. Hess, OSMA Director of Communications

Cleveland Rodgers has been with the Oklahoma Hospital Association for 29 years and currently serves as its Executive Director. The Oklahoma State Medical Journal arranged for this interview with Mr. Rodgers to discuss the future of the association and its members and the many changes which have taken place during the past three decades.

JOURNAL: Mr. Rodgers, based upon your long experience with the Oklahoma Hospital Association, can you very basically describe some of the differences between hospitals today and hospitals 20 or 30 years ago.

RODGERS: Twenty-nine years ago in Oklahoma, about 80 percent of the hospitals were proprietary hospitals, owned and operated by physicians. Oklahoma grew up so rapidly as a state that we didn't have time to build community institutions like some of the older communities and most of the other states had done. Therefore, for doctors to have a place to practice, they had to build their own hospitals. Many of them took over older homes and converted them into hospitals, and some of our smaller communities had two or three different hospitals. But with the incentives that the Hill-Burton program provided, which was passed in the latter part of the 1940's, Oklahoma physicians were very eager to get out of the hospital business. They urged the communities to build community hospitals by taking advantage of the Hill-Burton funds, and as a result of that, most of the hospitals were then financed by general obligation bonds or by private philanthropy, using some of the federal Hill-Burton hospital construction funds.

JOURNAL: Would you briefly describe the principles behind the Hill-Burton program?

RODGERS: The Hill-Burton program was primarily an incentive program for rural communities to build adequate hospital facilities. It had to be a non-profit organization, and Hill-Burton provided matching money of approximately 50 percent of the total cost of construction during the early days. So if a community could justify the need for a community hospital and build according to Hill-Burton standards, they could then get up to 50 percent of the total capital cost for the hospital. The community raised most of the other 50 percent through general obligation bonds and in some cases private philanthropy. As a result of that, most of the proprietary hospitals in the state of Oklahoma were closed when the community built adequate community hospitals. Therefore, until about ten years ago, most of the hospitals in the state were debt free because the capital construction costs had come from these other sources. But after the Hill-Burton funds dried up and the voters became skeptical of the



"Oklahoma grew up so rapidly as a state that we didn't have time to build community institutions . . . " voting additional general obligation monies, hospitals, to modernize and expand their facilities, had to borrow long-term loans. So today, Oklahoma hospitals have about a $500 million indebtedness. This is a big factor in increased hospital costs.

JOURNAL: One of the principal problems physicians face today and one of the contributing factors to the increase in the cost of medical care is the malpractice insurance problem. Do the hospitals in this state face a similar problem?

RODGERS: This is a very realistic and serious problem to Oklahoma hospitals. Malpractice insurance rates have increased from 300 to 400 percent in the last year or two. Many of the rates are so exorbitant that to get the coverage that they've had in the past, hospitals will have to raise their room rates three or four dollars a day just to pay for these increased premiums. As a result of that, many of the smaller hospitals have decided not to carry malpractice insurance; some of the larger hospitals have decided to go the self insurance route, meaning they just put the insurance premiums in the bank and hope that any judgments from malpractice suits will be able to be settled out of the premiums that they put in their self insurance fund.

We still see no solution to this problem. At the present time, the Hospital Association has a committee to explore the possibility of setting up a captive insurance company for just Oklahoma hospitals. One of the big questions is: Can we get some re-insurance if we set up this company? This is what we are studying at this time.

JOURNAL: What is the loss experience for hospitals in this state? Do you believe the insurance companies are justified in increasing their rates as much as they have?

RODGERS: We are shocked at the rates that the insurance companies are charging Oklahoma hospitals, because our experience on malpractice suits has been fairly good. We can't quite understand the exorbitant increase in rates. We are having these 300 or 400 percent increases in premiums each year. Many of the companies are no longer interested in writing hospitals, and we are experiencing some difficulty finding those that will offer protection. Many of them are also limiting the coverage that they will offer the hospitals. They're going up in their rates but still cutting back the dollar limits on the coverage. About 12 state hospital associations have already considered or are in the process of setting up an insurance company that would help them solve this serious problem. That's what we're doing also.

JOURNAL: What other factors are contributing to increased hospital rates? Do you see this increase stabilizing any time in the near future?

RODGERS: I think probably one of the greatest factors in the increase in hospital costs, of course, is the payroll cost that hospitals have. We are primarily in the people service business, and about 2/3 of our total cost is our payroll. In other words, as a rule of thumb, for every hospital patient that you have, you have two full-time employees on the payroll.

Payroll costs are going to go up, and we don't see anything that is going to reduce the use of personnel in hospital service. It's such a personal service and it can't be automated. With the rapid advances of the medical sciences,

we'll probably have to have larger staffs in our hospitals and more highly-trained technicians. I see nothing on the horizon that is going to stabilize hospital costs in the immediate future.

I do think there are two things that might help in the area of cost. One is to take a careful look at hospitals before they expand their facilities. The newly formed health planning agencies are going to make sure that we use our resources efficiently before we enlarge them and before we build new health care facilities. We think this will be good, and will contribute to some stabilization of hospital costs. Secondly, we are seeing that more and more patients are being cared for on an ambulatory basis rather than on inpatient basis. The hospital outpatient departments are growing at a terrific rate and we think this is a healthy sign because fewer patients will be admitted for inpatient care.

JOURNAL: The entire field of medicine has probably undergone more regulatory action than any other profession or industry in the country. Has this increased regulatory effort had any effect on hospital costs?

RODGERS: This certainly is a factor. We think that the hospital industry is probably the most regulated industry in the United States. Someone estimated that they had to report to 79 different regulatory agencies. So we are very heavily regulated, and this does have a serious impact upon our administrative costs. The hospital is a very complex institution, and it requires some real expertise in management. The average hospital administrator has to be extremely knowledgeable in hotel management, personnel management, pharmacy management, food service management, laboratory management, etc. He has to be an educator because more and more of your para-medical people are receiving their educational clinical training within the hospital. It's a very complex institution to manage.

JOURNAL: Some people are very critical of the medical profession because they believe in some respects it has done too good of a job. In other words, they say that through medical advances the profession is pricing itself out of the market and the general public can no longer afford necessary medical care. What is your reaction to that criticism?



"Malpractice insurance rates have increased from 300 to 400 percent in the last year or two."

RODGERS: This is something we hear very frequently from critical legislators as well as the public. I think the big question is this: Will we ever reach the stage where people will be denied medical and hospital care because they do not have the money to pay for it?

I think the facts are that this is not a problem today. People receive medical and hospital care that are in need of it regardless of their ability to pay. I think we've got to alert the public to budget for their health care needs, as they budget for housing and as they budget for everything else. This is why we encourage people to purchase a very comprehensive health care insurance.

We also believe that the government is going to have to work out better financing for care of the poor, the unemployed and the near poor. These people receive care now, but if the government doesn't finance this care, then the hospital is forced to ask the sick patients to pay an additional tax and to pick up the tab for these people. This accelerates the cost to the private patient, and we think this is very unfair. But I still contend that the people who need hospital or medical care in Oklahoma can and do get that care regardless of their ability to pay.

JOURNAL: The public also views the movement toward more and more private room institutions as being somewhat ironical when you consider that basic costs have increased as

much as they have. Why have most new hospitals emphasized the private room?

RODGERS: This is a response to the public demand. It's ironical that people in Oklahoma wouldn't consider going to a hotel and being placed in a room with a complete stranger, and yet when they go to the hospital they're placed in a room with a complete stranger. The public is demanding more and more privacy in hospital care, and rightly so; the cost is not significant. It costs just about as much to care for a patient in a multiple-bed room as it does in a private room. The major difference in cost is merely in your capital outlay for the building itself, and for that reason the public is demanding more and more privacy when they are ill. Many physicians feel that it is important for the patient to be in a private room rather than a multiple-bed room. For that reason also hospitals are responding to this demand, and I think you will see more and more hospitals being converted into private room institutions.

JOURNAL: Has any research been conducted which proves that the private room contributes to improved medical care? In other words, does the patient get well quicker in a private room than he does in a multiple-bed room?

RODGERS: Many physicians are certainly convinced that in many of the illnesses it is imperative that the patient receive his care in a private setting. We are finding also that families seem to take better care of their members when they're in a private room. We think all of this is conducive to good patient care.

JOURNAL: One of the most frequent criticisms we hear, particularly in the Oklahoma City region, is that hospitals have simply overbuilt. Is there a serious overbedding problem in this state, and if so, what is the reason for it?

RODGERS: In Oklahoma I personally don't believe that we have a serious overbedding problem. I think Oklahoma is extremely unique in that regard. As of today we only have six towns outside of Oklahoma City and Tulsa that have more than one hospital, and I think that's rather remarkable. Twenty-five years ago we had 30 towns that had two or three small hospitals. Most of those have now been closed.

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". . . many of the smaller hospitals have decided not to carry malpractice insurance . . ."

It is quite true that there has been a lot of publicity in Oklahoma City over overbuilding hospitals. It is also true that there are some empty beds in a few of the hospitals in Oklahoma City. But I don't believe this is a serious problem. I think in the next few years these beds will be properly utilized. Most people don't realize that you can't build a hospital one bed at a time. It takes about ten years for planning, designing and construction. So you've got to be a little bit of a prophet. You've got to predict what the population will be in your community ten years from now, how many physicians you will have in your community and what the needs will be. I think we've done a remarkably good job in Oklahoma, and we don't have a serious problem. Oklahoma City has some surplus beds now, but I believe in the next five years they will be properly utilized.

JOURNAL: Are hospital services, particularly for the critically ill, distributed poorly in this state?

RODGERS: We must face the fact that every hospital in the state cannot furnish all the services or all the needs of the people at that location. I don't think this will ever change. A lot of critically ill patients are going to have to be transferred to regional centers or to one of the major metropolitan centers to receive the specialty care that they need. I think the important thing for the public to realize is with very few exceptions there is an acute general hospital within 25 miles of every citizen in the state of Oklahoma.

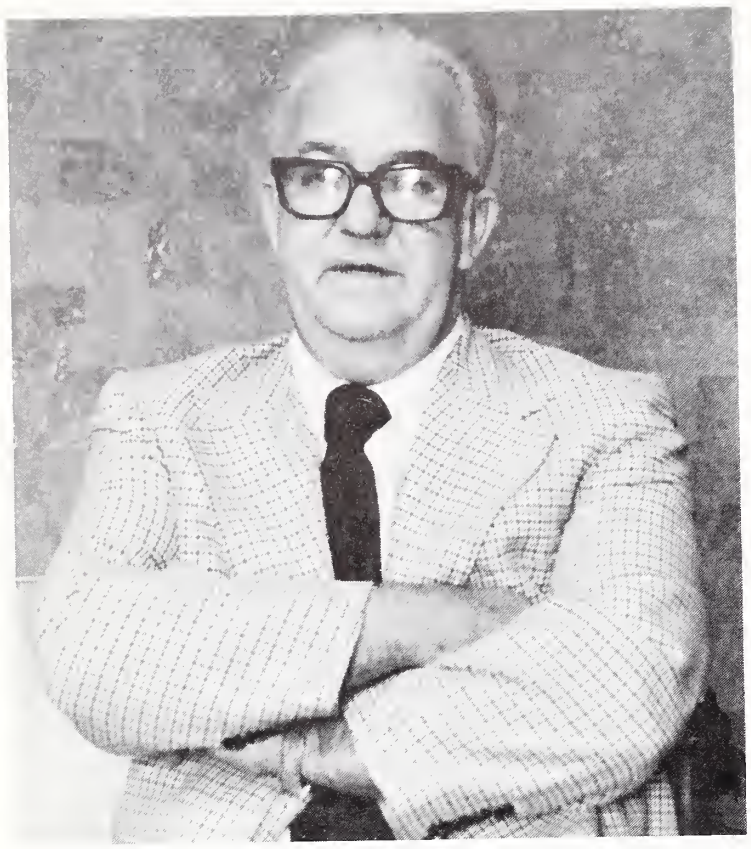
JOURNAL: One of the on-going problems which the entire medical community faces is the shortage of trained health manpower. What has and is being done to remedy this situation?

RODGERS: In the last decade we've made terrific improvements in meeting our health manpower shortage in the state, particularly in the nursing area. We are now producing a considerably larger number of both associate degree nurses, baccalaureate degree nurses and other health manpower. We still have a shortage, though and we still have a maldistribution problem. Some of the rural communities have difficulty getting adequate registered nursing coverage. But we've made such great strides that we're rather optimistic. We think we're going in the right direction.

The significant thing that has happened in Oklahoma in the last decade is that the educational institutions have now gone into the para-medical educational programs rather than the hospitals having to do all of it. Twenty-five years ago we had 28 diploma nursing schools financed and operated in hospitals. Today we only have one diploma school left. The junior colleges, the universities and the other colleges have taken over the basic education of many of the health manpower needs of the state. The hospitals are only having to furnish the clinical training for the nurses and the para-medical people. We think this is a very encouraging sign. In the near future our educational institutions should be able to alleviate our shortage of health manpower.

JOURNAL: Hospitals, of course, rely rather heavily on nursing care. Does the fact that the diploma nursing program in this state is now almost extinct present a problem? Does a serious gap in training exist between the associate degree nurse and the baccalaureate degree nurse?

RODGERS: We're very grateful for the caliber of the associate degree nurse. We think they are meeting a real need. We are finding



"We think that the hospital industry is probably the most regulated industry in the United States."

that in many cases hospitals have to have a lengthy orientation and training program for them — additional training you might say. But we are very well pleased with the caliber of the associate degree.

There does seem to be a trend for more and more baccalaureate degree nurses, and we think this is very healthy. But still the backbone of nursing in Oklahoma is the diploma nurse. We can see in the future, however, that a majority of our professional nurses will probably be baccalaureate degree nurses.

JOURNAL: Are the educational institutions in this state providing for all of our health manpower needs, or are there still certain specialists which we have to recruit from out of the state?

RODGERS: We have pretty good programs available in Oklahoma for practically all of our health manpower needs. We do not have all of them such as nurse anesthetists. But generally speaking with the Health Sciences Center, allied health manpower training programs and with many of the educational institutions getting very actively involved in education of health manpower, we think we can generally meet our health manpower needs by training them within the state.

JOURNAL: You have already described the changes which have taken place in our hospitals during the past 29 years. What changes do you see taking place in the future?

RODGERS: First of all I see the physician playing a larger part in hospital management in the future. I think the fact that more and more physicians now are serving on governing boards of hospitals is good. I think that hospital management needs input from physicians because only the physician is going to deal realistically with some of the hospital costs. In effect, the physician determines what services we give to our patients, how long they stay, and what type of care and equipment that the hospital has to serve them. I think secondly we are going to see more and more patients cared for in hospitals on an outpatient basis. I see in the future more and more of hospital services being carried out to the community or into the patient's home such as home-care nursing, home-care food services for diabetic patients, home-care physical therapy and things of that sort. In other words, in the interest of economy I believe that hospitals are going to be asked to develop more services to care for patients under the physician's direction outside of the hospital itself. I think this will have some impact on the total health care cost. □

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OSMA President Refutes Alleged Medicaid Abuses



Orange M. Welborn, MD

OSMA President, Orange M. Welborn, MD, has refuted recent charges that physicians abuse the Medicaid system by saying, "The only way physicians in Oklahoma have abused Medicaid is by not charging for legitimate visits and services." Doctor Welborn released the statement in response to allegations made by Senator Frank E. Moss, D-Utah, that Medicaid is widely abused by physicians, administrators, and patients.

Doctor Welborn said, "Up to 70 per cent of the documented visits made to Medicaid patients in nursing homes are never billed for." He added that the true number of unbilled visits is probably even higher.

"If we don't even charge for a majority of our nursing home visits, I can hardly believe we can be accused of abusing the system," Doctor Welborn said in a statement released in September. He said it appeared that Senator Moss had made national generalizations about the health care profession based upon several isolated and unconfirmed incidents. Doctor Welborn said, "This does a disservice to both the medical profession and the public."

According to the OSMA President, information which is available through the welfare department proves, "The type and magnitude of the abuses alleged by Senator Moss simply do not occur here." He said the unprofessional activities Senator Moss says he uncovered in New York and several other states simply do not relate to either Oklahoma physicians or the Medicaid system in this state. He pointed out the Welfare Department keeps precise records about the way Medicaid funds are spent, and that these records prove that Medicaid dollars are spent for services rendered.

Bertha Levy, MD, Medical Director at the department, took a similar position saying, "The doctors here provide Medicaid patients with good service, and they often do things they know they will probably never get paid for." She said abuse of the system in Oklahoma is "very low" and ongoing and special surveys

(Continued on page 452)

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have turned up very little which could be considered out of the ordinary.

Doctor Welborn took issue with both the allegations made by Senator Moss and his methods. He said the medical profession would never allow conclusions to be based on such "isolated and unscientific" procedures. "For example," he said, "Senator Moss somehow concludes that if a physician decides to run a battery of tests on a Medicaid patient, it is proof of over utilization.

"What do Senator Moss and his colleagues expect doctors to do when a patient complains of being ill? Tests are our principal method of diagnosing illnesses and the fact that the senator's illness was faked does not change this at all."

He said that since both the senator and his colleagues lied when they complained of being ill, there were no illnesses to be diagnosed and, therefore, it didn't surprise him that tests were inconclusive and they were asked to undergo a long series of examinations. He said another reason such thorough examinations were conducted is the continuing malpractice insurance crisis.

Doctor Welborn added that the state association and private practicing physicians are cooperating in an effort to make all insurance systems as responsible and efficient as possible.

"These efforts", said Doctor Welborn, "are in direct contrast with the situation reported by Senator Moss." □

Prominent Cancer Specialists To Attend Conference

Several prominent cancer specialists from across the country will take part in a two-day conference to be held in Oklahoma City concerning new treatments of solid tumors as well as the controversies surrounding the treatment of breast cancer.

The program, scheduled for November 10th and 11th at Lincoln Plaza Forum, is sponsored by the Oklahoma Medical Research Foundation's Oklahoma Hospitals Breast Cancer Control Network and the American



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Cancer Society, Oklahoma Division, with the cooperation of the University of Oklahoma Health Sciences Center.

Among the featured speakers are John Costanzi, MD, Associate Professor of Medicine, University of Texas Medical Branch at Galveston; William Donegan, MD, Professor of Surgery, the Medical College of Wisconsin; John Horton, MD, Head of the Division of Oncology, Albany Medical College, New York; Charles Huguley, MD, Professor of Medicine and Chairman of Oncology, Emory University, and Chairman of Southeast Oncology Group, Atlanta; Martin Levene, MD, Deputy Director, Joint Center for Radiation Therapy, Harvard Medical School; G. Rainey Williams, MD, Professor and Chairman, Department of Surgery, University of Oklahoma Health Sciences Center; and Cindy Mantz, RN., Vice-President, Oncologic Nurses Society, St. Louis, Missouri.

Additional panel members will represent the Oklahoma Medical Research Foundation, the University of Oklahoma Health Sciences Center, and the University of Oklahoma School of Medicine in Tulsa.

Various sub-topics will be discussed under such major headings as Detection and Diagnosis, Diagnosis and Evaluation, Primary and Adjuvant Therapy, and Treatment of Advanced Disease. In addition, there will be a major discussion on advances in chemotherapy, including chemotherapy of sarcomas, malignant melanoma, colon and other malignancies of the gastrointestinal tract. □

Open House Planned By Inpatient Psychiatry Services

In celebration of the opening of modern new facilities for Inpatient Psychiatry Services, the University Hospital and Clinics has issued an invitation to all Oklahoma health care professionals to attend the community open house to be held Sunday, November 14th from 3-5:00 p.m.

The event will be held on floor 5E, Clinic Building, University Hospital, 800 N.E. 13th Street, Oklahoma City and is co-sponsored by Inpatient Psychiatry Services and the Department of Psychiatry and Behavioral Sciences. For more information, contact J. A. Montero, MD, Russell Johnson, PhD, or Jane Sullivan, ACSW at 405 271-5284. □

DEATHS

AVERILL STOWELL, MD
1912-1976

Tulsa neurosurgeon, Averill Stowell, MD, 64, died August 29th, 1976. A native of Buffalo, New York, Doctor Stowell was graduated from Johns Hopkins University in 1938. He taught at Columbia University in New York City and Cleveland Clinic before coming to Tulsa in 1947. Certified by the American Board of Neurosurgey, Doctor Stowell was a member of the American College of Surgeons and received a Surgeon of Distinction award at Albert Einstein Medical School, New York City.

LOUIS R. BAKER, MD
1932-1976

A 44-year old, Oklahoma City anesthesiologist, Louis R. Baker, MD, died August 27th, 1976. Born in Philadelphia, Doctor Baker came to Oklahoma City in 1971 where he served on the faculty of the University of Oklahoma College of Medicine until June, 1976. He was a 1957 graduate of Jefferson Medical College.

Doctor Baker was a Fellow of the American College of Anesthesiologists and a Diplomate of the American Board of Anesthesiologists. In addition, he held memberships in the American Society of Anesthesiologists, the International Research Society of Anesthesiologists, the Society for Obstetrical Anesthesiology and Perinatology and the Oklahoma City Clinical Society.

WILLIAM M. ALDREDGE, MD
1915-1976

William M. Aldredge, MD, 60, Bartlesville surgeon, died August 26th, 1976. A native of Holdenville, Oklahoma, Doctor Aldredge was graduated from the University of Oklahoma Health Sciences Center in 1941. Following military service with the US Air Force, Doctor Aldredge served his residency in surgery and began his practice at the Veterans Administration Hospital in Oklahoma City. Later he moved to Carlsbad, New Mexico, where he practiced until moving to Bartlesville in 1951. He was a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. □

The Facts About Swine Flu



Q. Flu viruses change every year; why is this change so significant?

A. Every year minor antigenic variations take place, which is referred to as antigenic drift. However, approximately every ten years or so a major antigenic shift occurs. When a major shift occurs the population is left virtually without immunity and in every occasion in the past, a pandemic has followed.

Q. Should all my patients receive the swine flu vaccine?

A. Actually, three types of vaccine have been developed. The bivalent vaccine (A/New Jersey (swine flu) and A/Victoria) should be used for your high risk patient — those over age 65 and others with chronic health problems. The monovalent vaccine (A/New Jersey strain only) is designed for your healthy patients between ages 18 and 65.

Q. What about the third vaccine?

A. The third vaccine, a bivalent split-product vaccine made by Parke-Davis, is recommended for your patients under age 18 who have chronic health problems. No vaccine has been developed for the healthy population under age 18.

Q. How can I obtain the vaccine?

A. Each of the vaccines will be available from the Oklahoma State Department of Health and distributed by local county health departments, or in the case of the 17 counties without health departments, by the local county coordinators. By now every physician should have been contacted about the program. The bivalent split-product vaccine is available by request only and each physician should assess the needs of his practice. No forms are available for the bivalent split-product vaccine.

Q. How effective is the vaccine? Can it produce influenza in my patients?

A. The A/New Jersey influenza vaccine will provide up to 80 percent immunity for the fall and winter flu season. It contains only killed viruses incapable of causing disease.

Q. What are the side effects of the vaccine? How common are reactions?

A. Most people will experience no side effects from the vaccine. In some instances, minor reactions (local symptoms or mild fever) will occur. Field trials, however, showed only a one per cent febrile reaction rate. Serious reactions are extremely rare.

Q. How much paperwork will be required for this program?

A. The packet of materials associated with the swine influenza program includes an instruction sheet for physicians, an information sheet for your patients and a combined data-registration form. It is recommended that registration forms be used by private physicians in accounting vaccine type, age groups and other pertinent information.

Q. If I administer the vaccine in my office, must I have the registration form signed by each patient?

A. If you are making no charge for the vaccine or its administration and you want coverage under the federal government's professional liability program, you must have the form signed by each patient. If you decide not to have each patient sign the form, you still should log the requested information. All forms are available from your local county health department or county coordinator. The bivalent vaccine forms (printed in red) have been distributed. The monovalent vaccine forms are in black ink.

Q. May I charge for administering the vaccine?

A. You may charge a nominal fee for administering the vaccine, but you may not charge for the vaccine itself since it will be provided at no cost to you. If any charge is made, however, you will not be eligible for the federal government's insurance program. The Oklahoma State Medical Association has not recommended an "appropriate administration fee" and has left this decision up to the individual physician.

Q. If I take part in this program and charge for administering the vaccine, will my personal professional liability insurance cover me?

A. Yes! The state health department says the swine influenza vaccine is a FDA approved biologic and offers no more risk than any other previous influenza vaccine.

Q. How will the public be informed about this program?

A. Through the news media and through an informed consent sheet.

Q. When will I receive my vaccine?

A. Shipments of the bivalent vaccine have already been received by the state health department. Small amounts of the vaccine will be delivered throughout the month of October and perhaps into November. The state has been divided into 15 districts, and monovalent vaccine will be distributed to these districts based upon the amount of vaccine available, the population of the district and if necessary a chance-type selection process. □

Research Foundation Moves Facilities

The Oklahoma Medical Research Foundation (OMRF) and Presbyterian Hospital have announced the relocation of the Foundation's research hospital facilities to Presbyterian Hospital, effective October 1st.

The agreement, announced shortly before October 1st by Ben C. Wileman, Chairman of the Foundation's Board of Directors and Executive Committee, and Harry M. Neer, President of Presbyterian Hospital, transfers Oklahoma Medical Research Foundation's 20 beds to Presbyterian for cancer, cardiovascular, and hematological disease patients of Foundation physicians. Before the move the Foundation operated its own hospital in the east wing of its research facilities at 825 N.E. 13.

Officials said that approximately 12 months ago, the staff, management, and governing board of the OMRF undertook a comprehensive evaluation of facility requirements needed to meet short- and long-range goals of the Foundation's research programs.

As a result of the patient transfer, the Foundation will expand its present outpatient clinic

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which last year handled more than 13,000 visits by Oklahomans. As with the research hospital, the outpatient facility is primarily concerned with ongoing clinical investigation involving cardiovascular and malignant diseases.

In addition, the Foundation plans to expand its laboratory facilities. Medical and basic research investigations are under way at the Foundation in cancer, heart disease, and blood disorders, as well as protein structure and function, biomembranes, and vitamins and nutrition. □

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

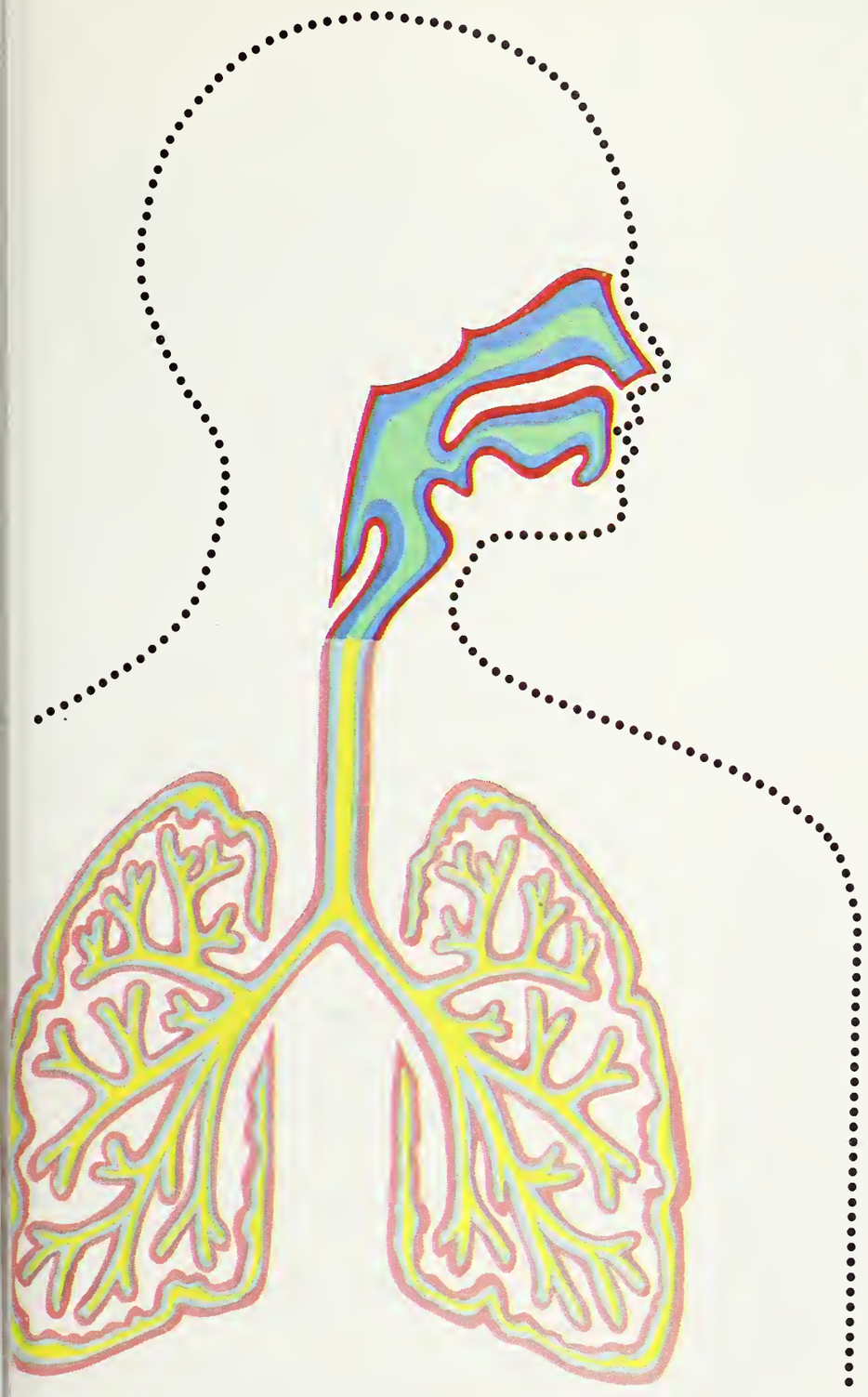
Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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Rynatan® Country

RYNATAN, for symptomatic relief of colds and allergic rhinitis. Convenient b.i.d. tablet and liquid dosage.

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RYNATUSS, for symptomatic relief of coughs due to colds and in acute and chronic bronchitis. Convenient b.i.d. tablet and liquid dosage.

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RYNATAN®: Each tablet contains Phenylephrine Tannate, 25 mg.; lorpheniramine Tannate, 8 mg.; Pyrilamine Tannate, 25 mg.

h 5 ml. (1 teaspoonful) RYNATAN® PEDIA-C SUSPENSION contains. Phenylephrine nate, 5 mg.; Chlorpheniramine Tannate, 2 .; Pyrilamine Tannate, 12.5 mg. CONVEN-T B.I.D. DOSAGE for convenience and econ-/.

ICATIONS: RYNATAN provides symptomatic :f of the coryza and nasal congestion asso-ed with the common cold, other upper iratory infections and allergic rhinitis. In sitis, drainage from the affected sinuses be improved.

TRAINOICATIONS: RYNATAN is contrain-ted in those patients who are sensitive to pathomimetic drugs.

CAUTIONS: Use with caution in patients hypertension, hyperthyroidism, diabetes or coronary artery disease: warn of possible drows-iness in patients who may operate vehicles or machinery.

AOVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

DOSAGE ANO AOMINISTRATION: RYNATAN TABLETS: 1 or 2 tablets every 12 hours.

RYNATAN PEOIATRIC SUSPENSION: For children over six years of age, 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours: for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

RYNATUSS®: Each tablet contains Carbetapentane Tannate, 60 mg.; Chlorpheniramine Tannate, 5 mg.; Ephedrine Tannate, 10 mg.; Phenylephrine Tannate, 10 mg.

Each 5 ml. (1 teaspoonful) RYNATUSS® PEDIATRIC SUSPENSION contains Carbetapentane Tannate, 30 mg. Chlorpheniramine Tannate. 4 mg. Ephedrine Tannate, 5 mg.; Phenylephrine Tannate, 5 mg. CONVENIENT B.I.D. DOSAGE for convenience and economy

INOICATIONS: In the treatment of coughs due to the common cold, asthma, and in acute and chronic bronchitis.

CONTRAINOICATIONS: RYNATUSS is contraindicated in those patients who are sensitive to sympathomimetic drugs.

PRECAUTIONS: Use with caution in patients with hypertension, hyperthyroidism, diabetes or coronary artery disease. warn of possible drowsiness in patients who may operate vehicles or machinery

ADVERSE REACTIONS: Drowsiness and dryness of the mouth are occasionally associated with antihistamine therapy in some individuals.

OOSAGE ANO AOMINISTRATION: RYNATUSS TABLETS: Adults—1 to 2 tablets every 12 hours.

RYNATUSS PEDIATRIC SUSPENSION: For children over six years of age. 5 to 10 ml. (1 to 2 teaspoonfuls) every 12 hours: for children two to six years of age, 2.5 to 5 ml. (½ to 1 teaspoonful) every 12 hours; for children under two years of age, 1.7 ml. (⅓ teaspoonful) every 12 hours.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

The above represents a brief summary. See package inserts for full prescribing information.

"JOIN US—WE CAN DO MORE TOGETHER." Ask your minister, priest, or rabbi why their religions are organized as city, state, and national groups; your neighbor why she needs to identify with YMCA in order to take a sewing class; your sister what she really receives from her membership in AAVW. The answer would probably be the same from each — "because the organization shares common concerns and goals in which I wish to share . . ."

So it is with our auxiliary. Our common interest centers in our husband's profession and its concern with better health of our people — and the conviction of most auxiliary members that we demonstrate this concern and make some contribution as an identifiable group to our communities.

WE NEED THE MEMBERSHIP OF EVERY DOCTOR'S WIFE IN OKLAHOMA. Because there is strength in sheer numbers, in shared visiable concerns, in a unified voice to our community and legislators. Because we need to project a positive public image in behalf of the physicians at a time when they are being portrayed as a self-serving profession by politicians and many other groups.

Many of our members have pioneered major community programs including Child Abuse Prevention, Health Career Recruitment, Nutrition Programs, Screening Programs, and Child Safety Programs to name only a few. The record of community service performed by the auxiliary is one that every member may proudly claim. In the area of legislation, auxiliary members have contributed beyond uncounted measure in hours of volunteer service. If you have not yet joined your local auxiliary, won't you do so now and add your voice to those who plead the case for Health Care.

Members-at-Large: If an auxiliary does not exist in your county, you may become a member of your state and national auxiliary as a member-at-large. There is much you can do as individual doctor's wives to help your physician husband in providing the best medical climate possible in your community. Your state and national chairmen have a wealth of information and materials to be used in promoting health related programs — for information contact the President, Mrs. James L. Haddock, 1028 Cruce, Norman, Oklahoma 73069. If you are already a member-at-large; please encourage other eligible wives in your area to join the auxiliary.

All eligible members are invited to join the auxiliary by filling out the membership application below and forwarding it to one of the following membership chairmen: Mrs. Orange M. Welborn, 208 East Kings Road, Ada, Oklahoma 74820; or Mrs. Homer C. Wheeler, 2015 South 13th, McAlester, Oklahoma 74501.

Join us—we can do more together. *Jo Welborn, Membership Chairman.* □

WOMAN'S AUXILIARY TO THE OKLAHOMA STATE MEDICAL ASSOCIATION MEMBERSHIP APPLICATION

NAME: Mrs. _____
(Husband's Name)

_____
(Wife's First Name)

ADDRESS: _____
(Street Number)

_____
(City)

_____
(Area Code)

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The JOURNAL
of the Oklahoma State Medical Association

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CONTRIBUTIONS

Articles accepted for publication, including manuscripts of annual meeting papers, are the sole property of *The Journal* and must not have been published elsewhere. Authority for approval of all contributions rests with the Editorial Board, and the Board reserves the right to edit any material submitted. Manuscripts should be typewritten, double spaced and submitted in original and one copy. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned on request. *The Journal of the Oklahoma State Medical Association* is not responsible for the statements or opinions of any contributor.

STYLE

Footnotes, bibliographies, and legends for illustrations should be submitted on separate sheets, double-spaced. Bibliographies should follow in order of: name of author, title or article, name of periodical with volume number, page and date of publication. These references should be alphabetized and numbered in sequence.

ILLUSTRATIONS

Illustrations, other than the author's will not be accepted for publication unless accompanied by written permission to be reproduced. Illustrations should be identified by the author's name and the figure number of the illustrations. The illustrations should be numbered in the same order as referred to in the body of the article. Used photographs, and drawings will be returned after publication if requested. *The Journal* will pay for necessary black and white illustrations within reasonable limitations. The quality of drawings, sketches, etc., must be in keeping with the quality of the magazine.

NEWS

Members of the Oklahoma State Medical Association, the constituent societies of the association, and all readers in general are invited to supply news items of general interest to the profession.

ADVERTISING

All advertising copy must be approved by the Editorial Board before acceptance for publication. General and miscellaneous advertising rates will be sent on request.

EDITING SERVICE

The Editorial Board reserves the prerogative to submit contributions to a Medical Editing Service when warranted. If such is felt necessary, the Editor will contact the author for approval, informing him that there will be a modest charge for this service.

REPRINTS

Authors will receive reprint order forms from the Transcript Press, P.O. Drawer 1058, Norman, Oklahoma 73069, prior to final publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

BACK ISSUES

Microfilm copies of back issues of *The Journal* may now be purchased from University Microfilms, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

One of the most common questions asked by physicians is: How long should I retain my patient records. Since this is such a common question, the OSMA asked our legal counsel, Roy C. Lytle, LL.B., to research the matter. According to Lytle, no law exists which states precisely how long a doctor or his family must maintain medical records. There are, however, two factors which should be considered. First, all records should be maintained as long as necessary if there is a malpractice lawsuit pending or the possibility of one developing. Second, records should be retained to aid a subsequent physician. In the case of a potential malpractice lawsuit, says Lytle, the records should be kept at least until the statute of limitations has expired. Under legislation passed this year, the statute of limitations for malpractice cases is two years from the date of discovery or in no event more than three years from the date of occurrence. Once that period has passed, a patient is entitled to recover only actual medical expenses and the risk of a large settlement or judgment is much less. If no such claims are known of or expected, says Lytle, patients should be notified that their records are available and may be delivered to them. Ideally, he says, undelivered records should be kept five years, although this presents storage problems.

Legislation designed to give the medical profession a mechanism for taking action against so-called "Medicaid mills" is moving swiftly through Congress. In mid-September, the U.S. Senate Finance Committee approved the bill sponsored by Sen. Herman Talmadge, D-Georgia and the full Senate was expected to act upon the measure in late September. The bill has been supported "in principle" by the AMA's Board of Trustees.

The Talmadge bill would strengthen HEW's fraud and abuse unit; increase penalties for Medicare-Medicaid abuse; and give PSROs the authority, at their request, to contract with HEW to review ambulatory care services in hospitals and in so-called "Medicaid mills."

In a statement released to the press, AMA President Richard E. Palmer, MD, said, "Given the necessary powers and authority, we of the medical profession will make every effort to put an end to the fraud and abuse in the Medicare and Medicaid programs which result from physician activity." He said, however, the problems of the two programs "have been ten years in the making" and are not going to be cleared up "in ten days, in ten weeks or even in ten months . . ."

Enter the FTC Commission again: The Federal Trade Commission recently announced plans to investigate the nursing home industry to determine if it engages in unfair or disceptive practices. The FTC explained that the probe will not deal with the quality of care but rather how nursing homes handle patients' money. The investigation will also center around advertising claims made by nursing home establishments and will look into "links" between nursing homes and pharmaceutical and other suppliers for possible kickbacks. The protection of patients' personal property will also be a part of the commission's study.

A project by the OSMA Council on Professional and Public Relations which is designed to put medical information at your patients' fingertips has been distributed to most physicians' offices. The project, a packet of materials entitled MEDICAL UPDATE, includes an attractive counter display and pamphlets on malpractice insurance, national health insurance and physician advertising. It will be used as the cornerstone of the OSMA's public relations effort and is designed to be changed as medical issues change. In an effort to avoid duplication and waste, only one packet will be mailed to offices where more than one physician practices. If more are needed, however, the OSMA will be happy to fill your order. If you have not received your packet, or if more are needed, write: Oklahoma State Medical Association, Department of Public Relations, 601 NW Expressway, Oklahoma City, Oklahoma 73118. Please allow 10-14 days for delivery. □

The JOURNAL of the Oklahoma State Medical Association

November
1976
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(Cover Art by William Cason)



The one the patient takes is never tested.

Surprising, perhaps, but it makes sense when you think about it.

Obviously, the actual dose of any prescription drug the patient takes cannot be tested because it would have to be broken down for analysis—after which it could never be used by a patient.

This means that you depend on the manufacturer for assurance that the dose the patient takes is identical to the ones which have been tested.

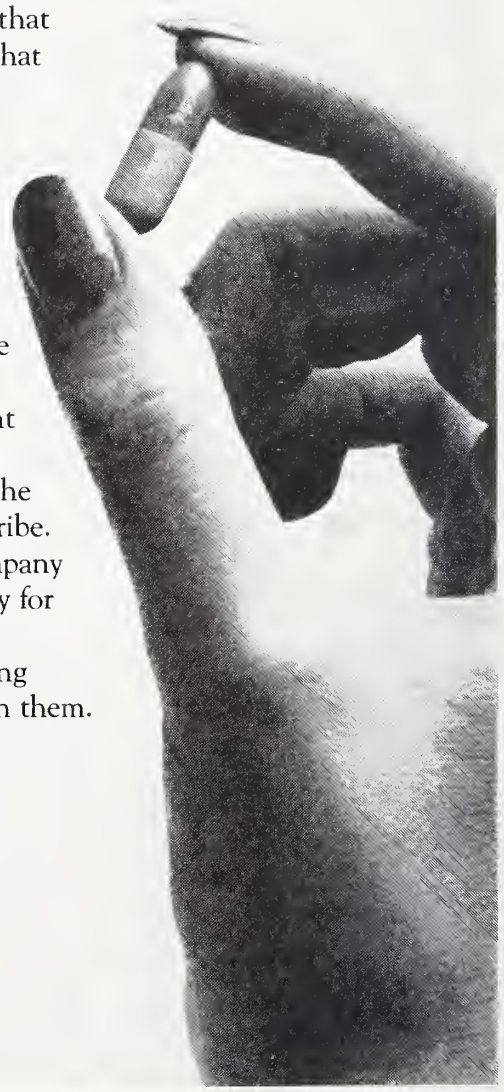
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FREE TURKEY

Back in the good old days, before the lawyers in Washington started practicing medicine, all of my patients could get their flu shots more or less at their convenience. They stopped by the office, asked for a flu shot and, if I approved their request, my nurse gave it to them. Complete records were kept and patients were billed in the usual way. They were charged for my professional service, the administration of the serum, the record-keeping and the liability involved in doing all of that. The cost of the serum, in contrast, was not significant. I would charge the same for giving sterile saline. My patients who could, paid me. The ones who couldn't, still owe me. But only those who got the shots paid for them — and that was that.

Formerly, I gave flu shots starting in late August each year. I ordered the necessary amounts of serum from the manufacturers and distributors, who stood accountable for their products, six-to-ten months prior to the desired date of delivery. I paid for it at the time of delivery — and it *was* delivered to my office.

This year, the flu serum is "free." It arrived two months later than usual, and it arrived miles away from my office. It wasn't delivered. My secretary left the office and made the round trip in her own car. She returned two hours later with one-fifteenth of the serum I had requested.

Meanwhile, back at the telephone, my office personnel were so busy answering questions from waiting and anxious patients, it became difficult for them to find time to care for the patients in the office. Also, I had to review again the list of names of my high-risk, high-priority patients and select the fraction which would be given the available serum. In addition to notifying each of them — which frequently required several calls — all the others had to be notified that there would be an indefinite delay before they could get their immunizations.

Of course, patients could no longer drop in for their shots; they had to make appointments in order to allow them sufficient time to read a two-page document of information, ask questions if they had any, receive answers, and affix their signatures attesting to their comprehension and consent. Patients whose visual acuity, ability to read and comprehend, or majority rights were compromised had to be accompanied by a responsible friend or relative who could function for them. Few waiting rooms I have seen can serve as reading-rooms for a dozen or more readers at one time — certainly mine cannot. Thus the need for scheduled appointments.

Now let's take a closer look at the "free" flu shot. How many government-paid lawyers spent how many hours drawing up the information-and-consent documents? How many tons of paper and red and blue and black ink were used in printing all the physician- and patient-instruction forms? How many government-paid printers spent how many hours producing the forms? How much did it cost to mail the forms? How much did the serum cost and how much did it cost to re-ship it from the manufacturers to the distribution centers? How much gasoline was used and how many hours of physician-paid employees' time were expended in getting the serum to doctors' offices? (And how many more trips will be made to pick up the parcelled-out serum?) How many hours will be spent in making and receiving telephone calls to-and-from patients and to-and-from distribution centers? How many hours will be spent by patients in reading and comprehending and signing the necessary documents?

Then there's the duplicate set of records to be maintained which more than doubles the usual time required to make the customary entries in the clinical records. How many hours will be spent completing these records and how much postage will be required to return them to the senders?

If any living human being or any bank of super-human computers could total-up the tab on this project, perhaps we could get a line on the true cost of Washington's latest free lunch. It's a real turkey, which everyone is paying for whether or not he got some of it — or even wanted it in the first place.

Hope you're having a pleasant Thanksgiving, and a much-less-expensive turkey! MRJ



This report will cover a very eventful month for me and for the Oklahoma State Medical Association. It was a month of decisions — decisions which will affect us all for some time to come.

On October 24th, the OSMA House of Delegates took strong action on two vital issues at a special called meeting in Oklahoma City. First of all, the House acted on a very important question involving unified membership with the American Medical Association. By a vote of 65-26, the House reaffirmed our unified position with the national association, marking the 27th consecutive year in which the OSMA has been unified with the AMA. The House action was later upheld by the OSMA Board of Trustees, acting as Judicial Council.

The second and perhaps most important action was to adopt a new concept in "Umbrella Insurance Coverage" for our members. That action will not only forestall a tremendous rate increase for each of us (200-300 per cent), but it will also save us over $1 million in premiums next year and provide a method of funding our own "excess limits" coverage. We all owe a debt of gratitude to the Council on Members Services, to its Chairman, C. Alton Brown, MD, and to Rod Frates and Don Blair of C. L. Frates and Co., for establishing this program for us.

One week after the meeting of the House of Delegates and Board of Trustees, the OSMA Council on Planning and Development spent three hard-working days studying the various programs of the OSMA. This was one of the most fruitful meetings I've attended in the last 20 years. It was a fruitful meeting for several reasons.

First, the new council reorganization is really working. Second, Arnold Nelson, MD, Chairman of the Council on Planning and Development did a splendid job of conducting a meaningful series of meetings, and third, it rained all weekend and no diversions such as tennis, golf, etc., were to be found — everyone worked and much was accomplished.

The Council reviewed OSMA programs, helped clarify priorities and directions, and studied several important issues which concern the entire association. Among these were the graduate medical education program in this state and a plan to enhance the association's role in disciplining our own members, rather than allowing outsiders, the laity, or governmental agencies to intervene in matters which should be handled within the profession.

In all, much was accomplished during the month of October. This association is on the move. It is getting things done and moving forward to meet its obligations to the people, to its members and to the profession as a whole. □



OSMA JOURNAL / scientific

A Workable Approach Towards Breast Cancer Control

ARTHUR F. HOGE, MD
Assistant Professor of Research Medicine and Assistant Professor of Biostatistics and Epidemiology, University of Oklahoma College of Medicine and Assistant Member, Oklahoma Medical Research Foundation

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Assistant Professor, Department of Biostatistics and Epidemiology, University of Oklahoma Health Sciences Center.

PAUL ANDERSON, PhD
Professor and Chairman, Department of Biostatistics and Epidemiology, University of Oklahoma Health Sciences Center.

Analysis of 2,459 patients revealed problem areas amenable to control measures. A program of early detection has resulted in improved staging at first diagnosis. Primary therapy should become more flexible with staging and tumor aggressiveness being influential factors. Adjuvant chemotherapy is being utilized.

Breast cancer continues to be one of the most perplexing problems facing women and their physicians. Cutler[1] has shown a slow, almost imperceptible improvement of end-results in each five-year period since 1940. However, because of increasing incidence, the mortality has not changed. This improvement has not been related to any change in therapeutic regimens, that is, specifically the extent or quality of surgery or adjuvant use of radiation therapy, but is related to earlier detection.

From the Oncology Section, Department of Medicine and the Department of Biostatistics and Epidemiology, The University of Oklahoma Health Sciences Center; The Oklahoma Medical Research Foundation, Oklahoma City, Oklahoma.

Supported by: The National Cancer Institute under Contracts Number NOI-CN-45137 and Number CA 169-01.

As one of the twelve National Breast Cancer Clinical Demonstration Projects, twenty-three hospitals doing breast cancer work were identified and brought into the program; a framework for administrative management was established; and several functioning committees were organized.

A Coordinating Committee was established with members of surgery, medicine, radiation therapy, radiology, family practice specialties as well as productive lay persons known to be active in the cancer field and representatives of the American Cancer Society.

A Developmental Therapy Committee was organized to function as an overseer of 1) the basic and clinical research, 2) reports from oncology cooperative groups, 3) world literature (obtained through computerized print-outs monthly), and 4) data accumulated from the project. Representatives usually attend the meetings of the Breast Cancer Task Force and minutes of these meetings are in the project office. Whenever informative data or important research findings become apparent, they are summarized and reported to the Network participants. Communications involve newsletters, bulletins, state medical and other journal publications, and direct reports from the Consultants Committee.

If clinical research protocols prove to be better than currently recommended therapy, they are rewritten into "patient management plans" which are subject to review and modification by the Consultants Committee.

The Consultants Committee is composed of 76 multi-disciplinary specialists utilized primarily to provide consultative advice to hospital Tumor Boards in community hospitals. They receive reports from Developmental Therapy, appraise them for feasibility and practicality for submission and discussion in hospital Tumor Board or Conference meetings. These meetings are held at least once monthly in each of the Network hospitals and are attended by surgeons, medical oncologists, radiation therapists, pathologists, and oncologic nurses.

Four oncology nurses were recruited and given special training in cellular biology, cancer pathophysiology, cancer detection, nursing care of surgical and radiation therapy patients, rehabilitation, chemotherapy, immunology, immunotherapy, and investigative protocol procedures and follow-up.

A Biostatistical and Epidemiologic section has been contracted with the University and evaluation committees have been activated. Specialized committees on rehabilitation, professional education, public education, and others have been coordinated with the American Cancer Society.

A baseline, three-year study of 2,459 breast cancer patients in twenty-three hospitals over a three-year period from 1971 to 1974 has been completed. Of these 1,792 (or 73%) were newly diagnosed and 410 (or 17%) were admitted for recurrent disease. The remaining 10% were follow-up referral treatments.

Analysis by stage of the 1,792 patients revealed in situ diagnosis in 4.5% of the patients, localized tumors in 48%, positive nodes in 35% and extended disease involving the chest wall or extensive skin in 8%. An additional 5.7% had wide dissemination at the time of first therapy. This figure may be low because routine metastatic surveys were very infrequently done at the time of first therapy. Fifty-eight or 3% were not staged. (Table 1)

A diagnosis of in situ carcinoma was made in 83 patients, but the frequency distribution was quite different from one hospital to another ranging from 0% to a high of 17.9%. The diagnosis of intraductal or comedo carcinoma was accepted only after multiple sections of all breast quadrants were reported from a totally excised breast. Pathology review has not been possible at this time, but professional education as an active part of the program and re-

TABLE I

DISTRIBUTION OF BASELINE CASES BY STAGE
NEWLY DIAGNOSED CASES 1971-1973

STAGE OF DISEASE	NUMBER OF CASES	PERCENT	
In situ	80	4.5	
			52.3
Localized	856	47.8	
Extended	69	3.8	
Nodes	553	30.9	
Nodes Extended	73	4.1	35
Wide Dissemination	103	5.7	
Not Staged	58	3.2	
TOTAL	1792	100.0	

TABLE II

HISTOLOGICAL VARIETY OF BREAST CANCER INTO FOUR CLASSES ACCORDING TO TUMOR AGGRESSIVENESS

CLASS	HISTOLOGICAL VARIETY
I	Intraductal papillary carcinoma Lobular carinoma in situ Paget's disease confined to skin Paget's disease with ductal involvement, without invasion Intracystic carcinoma in situ Intraductal (comedo) carcinoma
II	Medullary carcinoma Mucinous carcinoma Well differentiated tubular carcinoma Adenoid cystic carcinoma
III	Infiltrating ductal carcinoma Papillary carcinoma (NOS) Squamous cell carcinoma (NOS) Adenocarcinoma (NOS) Lobular carcinoma Paget's disease with ductal invasion
IV	Undifferentiated carcinoma (NOS) Undifferentiated adenocarcinoma Inflammatory carcinoma Cystisarcoma phylloides, malignant

commendations for more frequent use of consultation as well as separation of biopsy treatment into two stages is being done in marginal cases. Of equal interest is the variability of stage at first diagnosis versus classification of tumors. The various histological types were compiled and divided into four groups according to tumor aggressiveness. (Table II) Class I tumors comprised all of the in situ histological types. Class II consists of tumors with relatively favorable prognosis — ie, well-differentiated tubular, mucinous, medullary, and the rare adenoidcystic carcinoma. Class III is made up of the infiltrating ductal carcinomas, scirrhous carcinomas, and adenocarcinomas. Class IV is composed of the undifferentiated type of tumor with a diffuse ill-defined margin and inflammatory carcinoma.

Comparing stage at first therapy to classification of tumor revealed significant findings which would suggest modification of the primary therapy. (Table III) All of the Class I tumors were confined to the breast without fascial or nodal involvement. A less aggressive approach — a total or simple mastectomy with or without lower axiliary node sampling would have been adequate. Seventy-three percent of the Class II tumors were localized with only one showing fascial or muscle involvement and only 20% having nodal metastases. It is noteworthy that 3% had distant spread. Because of these and other data from the literature the program has approved a modified radical mastectomy as being quite adequate in the early stage of these tumors. However, if nodal metastases are present, the possibility of distant spread is as great as that in other malignancies. Class III tumors, by far the most common, were found to have 9% of the tumors extending beyond the breast proper or with wide dissemination. An additional 39% of the patients had nodal metastases. Recommended therapy in this group of patients would depend upon the stage of the disease after proper assessment. Early Stage I lesions with a tumor size less than two centimeters and no involvement of fascia probably could be managed efficaciously and safely with a modified radical mastectomy. Larger tumors and those deeply situated in the breast should probably have the standard Halsted type of mastectomy though we realize the use of adjuvant chemotherapy or

TABLE III
STAGE VS. TUMOR CLASSIFICATION FOR NEWLY DIAGNOSED CASES
(1971-1973)

	Stage											
Class	In Situ		Localized		Extended		Nodes and Nodes Extended		Wide Dissemination		Total	%
I	84		0		0		0		0		84	4.9
II	0	(0%)	45	(75%)	1	(2%)	12	(20%)	2	(3%)	60	3.5
III	0	(0%)	778	(52%)	60	(4%)	583	(39%)	69	(5%)	1,490	87.8
IV	0	(0%)	14	(22%)	6	(9%)	30	(47%)	14	(22%)	64	3.8
Total	84		837		67		625		85		1,698	
%	4.9		49.3		4.0		36.8		5.0			

radiation therapy may modify this approach. Class IV tumors have proven to be very formidable and certainly every effort must be made to correctly define the extent of disease before definitive therapy is completed. Distant spread was noted in 22% of the patients and 45% had positive nodes. Some of these patients presented with distant spread without evidence of nodal disease or in a few instances, without a dominant breast mass. Certainly the risk of adjuvant chemotherapy with or without radiation therapy would be justified.

The actual treatment given these patients varied widely from one physician to another and even from one hospital staff to another. Although individual analysis has been done, group presentations seem more appropriate. Treatment employed in the baseline data tended to be somewhat stereotyped with a large number of physicians employing radical mastectomy in all stages of tumors.

Analysis of the treatment in Class I or in situ lesions (Table IV) revealed either a modified radical mastectomy or radical mastectomy being employed in more than 71% of these tumors while a simple mastectomy was utilized in only 24%. Of the patients receiving some type of radical mastectomy, six had additional radiation therapy and one had an endocrine ablation and three had other systemic therapy! None of these patients had disease outside of the breast proper and none had nodal metastases.

At the other end of the spectrum, 18% of those patients who had known widely disseminated disease had either a modified or a radical mastectomy while 42% had radiation therapy as part of local disease control. Only one patient had an endocrine ablation as part of her primary treatment. Systemic therapy was generally employed as outpatient follow-up care and varied widely from simple hormones to variable combinations of cytotoxic agents most commonly used sequentially rather than in combination.

In the treatment of localized disease, 79% had a radical mastectomy; 11% had a modified radical; and 8% a simple mastectomy. Fourteen percent of the patients had additional radiation therapy. Most of these had medial quadrant or central lesions. Four percent of the patients had adjuvant systemic therapy.

Of the patients with positive nodes, 48% had adjuvant radiation therapy while only 9% had adjuvant systemic therapy. Again, 79% had a radical mastectomy and 18% had a modified radical. Less than 1% had a simple mastectomy.

TABLE IV

PRIMARY TREATMENT BY STAGE
BASELINE DATA VS. 1975

STAGE		TREATMENT							
		SM		MRM RM		RADIOTHERAPY		SYSTEMIC THERAPY	
		#	%	#	%	#	%	#	%
In Situ	BASELINE	19	23.8	57	71.3	6	7.5	4	5.1
	1975	3	14.3	16	76.2	–	–	3	14.3
Localized	BASELINE	71	8.4	771	90.5	121	14.2	36	4.2
	1975	13	4.9	248	93.9	36	13.6	13	4.9
Nodes	BASELINE	5	0.8	601	96.6	301	48.4	55	9.0
	1975	1	0.7	141	96.6	76	52.0	13	9.0
Disseminated	BASELINE	18	17.5	19	18.4	43	41.7	58	56.3
	1975	5	12.2	7	17.1	10	24.3	17	41.5
TOTAL	BASELINE	134	7.8	1476	85.5	404	23.4	168	9.7
	1975	28	5.7	421	86.1	128	26.2	47	9.6

SM-Simple Mastectomy MRM-Modified Radical Mastectomy RM-Radical Mastectomy

TABLE V

OKLAHOMA HOSPITALS BREAST CANCER CONTROL NETWORK

Accrual of Newly Diagnosed Breast Cancer Cases by Type of Hospital for 1971-73 and 1975

TYPE OF HOSPITAL	ANNUAL NUMBER OF CASES 1971 — 73*	1975	PERCENT CHANGE
Participating Oklahoma City & Tulsa	426	444	4.2
Resource and Delivery	172	252	46.5

*Average

Analysis of these data revealed several areas where improvement might be possible — earlier detection, application of more rational choices of primary therapy, the use of investigational studies in adjuvant chemotherapy and the more aggressive treatment of advanced or metastatic disease. Rehabilitation was not often used despite availability of Reach to Recovery personnel, physical therapists, vocational rehabilitation and mental health persons.

A massive program directed toward early detection has been implemented. Of 1300 nurses given oncologic nurse training throughout the state, 350 have been trained to be instructors in breast self-examination and recruited into the program. The American Cancer Society has been involved in an extensive public education program and the mass media, including television, radio and newspapers have all contributed generously to public education. Some 65,000 women have now been trained in breast self-examination with the use of films and the "BETSI" mannequin containing simulated breast lumps.

First year results revealed some significant differences in case accrual and in the staging at first treatment. This is particularly true in the hospitals in the smaller communities throughout the State. (Table V) Analysis of case accrual in 1975 versus the average of the three-year baseline data reveals no significant changes in the large metropolitan hospitals. There was a 4% increase in these hospitals but this represented a trend parallel to the increase in beds and patient admissions. The resource hospitals of the smaller communities did reveal a significant change with an increased case accrual rate of 46.5% in 1975. This is impressive when one considers that many of the smaller communities did not have adequate public education programs until the mid part of the year. Staging at first therapy in these same institutions revealed an increase in proportion of patients with localized disease and a corresponding decrease in those patients who had positive nodes or extended disease. (Table VI) The change, although small at the present, is statistically significant at the 10% level. There has been an increase in the diagnosis of wide spread disease at the time of first treatment directly related to the more frequent use of metastatic surveys being accomplished during initial diagnostic evaluation. Analysis of the frequency distribution by tumor classification revealed almost identical break-down with 5% being in situ and 88% being ductal carcinomas of the Class III variety. The Class II tumors were localized in all but three instances in which nodal metastasis was found (11.5%). (Table VII)

In the current data we still noted a preponderance of in situs being treated with either a modified or standard radical mastectomy

TABLE VI

DISTRIBUTION OF STAGES BY TYPE OF HOSPITAL BASELINE (1971-73) AND CURRENT DATA (1975)

	IN SITU		LOCALIZED		NODES		WIDE DISSEMINATION	
	#	%	#	%	#	%	#	%
Participating Hospitals								
Baseline Data	56	4.4	609	48.3	393	31.1	73	5.8
CURRENT DATA	15	4.9	156	50.5	86	27.8	24	7.8
Resource Hospitals								
Baseline Data	23	4.8	226	46.8	149	30.8	27	5.6
CURRENT DATA	3	1.7	103	56.9	42	23.2	12	6.6

(76%), but no adjuvant radiation was utilized. (Table IV) As expected there was no case of extended or nodal disease.

Therapy of localized disease was by surgery alone in 84% of the patients. Adjuvant radiation therapy was employed in 14% and other types of systemic therapy were noted in 5% of the patients, most of which were the Class IV type. Radiation therapy continued to be utilized in the same proportion of patients with positive nodes — 52% (3% of whom had radiation as the principal mode of therapy). Adjuvant radiation therapy was more commonly used in the smaller hospitals as compared to the larger institutions.

Discussion

Breast cancer screening centers have been effective in early detection of breast cancer with 80-90% of the patients having no nodal metastasis.[2,3] The apparent lead time in diagnosis in these centers is approximately one year.[4] Other breast cancer detection centers employing physical examinations on a yearly basis and monthly breast self-examination have noted similar improvement in end-results, with 88% of their patients surviving five years and 74% surviving ten years.[5] Breast cancer screening centers have been set up in several areas of the State including Tulsa, Ada, Lawton, and a large screening demonstration project at the Oklahoma Health Sciences Center. Results of these investigations are not yet in. Many hospitals also have xeromammography and/or mammographic equipment. Nevertheless, the logistics of supplying well-trained mammography radiologists and radiological technicians for this type work together with the manpower required of screening all women in the state is not practical at this time. Consequently, this program has relied upon both professional and lay education to identify high-risk groups, who are then channeled into screening centers, but the major effort of detection is through nurses and the BSE program. The initial enthusiasm has carried it forth with great effectiveness. The influence of breast cancer having occurred in two of our Nation's most prominent people was recognized. However, this influence should have been equally noted among people in the larger urban populations, which group has not shown the same results as the smaller communities where our program has been much more active.

The treatment of minimal disease is now a subject of great importance. While there are proponents for both minimal and maximal surgery, we feel that a more middle-of-the-road course could be effectively undertaken at this time. Wanebo[6], Urban[7], Farrow[8], and Westbrook[9], and others have shown modified radical mastectomy to be an effective treatment in those patients with very early cancers. It would appear from these data that a simple mastectomy or extended simple mastectomy to include sampling of the lower axillary nodes would be quite adequate for the in situ lesions when one can be sure of the diagnosis. While the ductal in situ lesion or comedo carcinoma cannot be properly diagnosed until the entire breast has been removed, we feel that the lobular carcinoma in situ, the intracystic carcinoma in situ, and the papillary carcinoma in situ diagnosis can be made from totally excised lumps after multiple studies on permanent sections.

Because of the infrequent involvement of muscle in Class II tumors, a modified radical mastectomy may be done with great functional and cosmetic advantages.

TABLE VII
STAGE VS. TUMOR CLASSIFICATION NEWLY DIAGNOSED CASES
(1975)

	Stage						
Class	In Situ	Localized	Extended	Nodes and Nodes Extended	Wide Dissemination	Total	%
I	31 (91.2%)	3 (8.8%)	0 (0%)	0 (0%)	0 (0%)	34	5.0%
II	0 (0%)	23 (88.5%)	0 (0%)	3 (11.5%)	0 (0%)	26	3.8%
III	0 (0%)	328 (54.8%)	28 (4.7%)	200 (33.4%)	43 (7.2%)	599	87.8%
IV	0 (0%)	6 (26.1%)	2 (8.7%)	6 (26.1%)	9 (39.1%)	23	3.4%)
Total	31	360	30	209	52	682	
%	4.5%	52.8%	4.4%	30.6%	7.6%		

Adjuvant radiation therapy in those patients with positive nodes or with medial quadrant or central lesions continues to be utilized by some physicians. This varies highly from one institution to another. There has been a decrease in radiation therapy in most of the larger institutions during the past year. A recent analysis revealed 60% of surgeons recommending adjuvant chemotherapy in patients who have positive nodes or who have Class IV type lesions. Some of these physicians are using radiation therapy as well as chemotherapy. End-results are not at this time available.

While many physicians criticize Fisher's L-PAM report[10] as being premature, the study is now in its fourth year and the survival of the treated patients continues to be significantly better than the untreated control in premenopausal patients.[11] Bonadonna's study utilized the three-drug combination of Cytoxan, Methotrexate and 5-FU as adjuvant treatment to the primary surgical attack on breast cancer![12] Results of this combination appear to be much better than a single-drug therapy. While we do not know the long-term effects, we have seen long-term results of adjuvant chemotherapy in other systems such as Wilms' tumors, neuroblastomas, sarcomas and ovarian tumors. Although there is a four-fold increase of second cancers in those patients achieving long-term survival, we feel that this risk is well justified when one considers the alternative![13]

Treatment of advanced disease has evolved from simple hormonal manipulation and subsequent single agent chemotherapy to more sophisticated and aggressive attacks with notable improvement in response rates and survival.[14, 15] Extended endocrine ablation to include either adrenalectomy or hypophysectomy is being done in both of the major metropolitan areas and in some of the smaller urban hospitals. Several physicians are now cooperating with the Developmental Therapy Committee and we have seen a large increase in patients on investigative protocols.

We believe that a new era in the management of breast cancer is emerging and we will probably see changes in end-results brought about by early detection, improved management of primary breast cancer, and hopefully, better therapeutic regimens for advanced disease. □

BIBLIOGRAPHY

1. Cutler, S. J., Heise, H. W.: Efficacy of Current Treatment Methods in Cancer of the Breast, *CA* **24**:1117-1122, Dec. 1969.

2. Whitney, L. W., Cancer Communique' — For the Delaware Cancer Network, *Del. Med. J.* 47:635-644, Nov. 1975.

3. Moskowitz, M., Russell, P.,: Breast Cancer Screening, *CA* **36**:2245-2250, 1975.

4. Shapiro, S., Goldberg, J. D., Hutchison, G. B., Lead Time in Breast Cancer Detection and Implication for Periodicity of Screening, *Am. J. Epid.* **100**:357-366, Nov. 1974.

5. Gilbertsen, V. A.: The Earlier Detection of Breast Cancer, *Seminars in Oncology* **1**:87-89, June, 1974.

6. Urban, J.: Changing Patterns of Breast Cancer, *CA* **37**:111-117, 1976.

7. Wanebo, H. J. Huvos, A. G., Urban, J. A.: Treatment of Minimal Breast Cancer, *CA* **33**:349-357, Feb. 1974.

8. Farrow, J. H.: Current Concepts in the Detection and Treatment of the Earliest of the Early Breast Cancers, *CA* **25**:468-477, Feb. 1970.

9. Westbrook, K. C., Gallager, H. S.: Intraductal Carcinoma of the Breast: A Comparative Study, Submitted *Am. J. Surg.* for pub. Dec. 1975.

10. Fisher, B., Carbone, P., Economou, S. G., Frelick, R., Glass, A., Lerner, H., Redmond, C., Zelen, M., Band, P., Katrych, D. L., Wolmark, N., Fisher, E. R.: 1-Phenylalanine Mustard (L-I AM) in the management of Primary Breast Cancer, *New Eng. J. Med.* **292**:117-122, Jan. 1975.

11. Proceedings of the Breast Cancer Task Force, Nov. 1975.

12. Bonadonna, G., Brusamolino, E., Valagussa, P., Rossi, A., Brugnatelli, L., Brambilla, C., De Lena, M., Tancini, G., Bajetta, E., Musumeci, R., Veronesi, U.: Combination Chemotherapy as an Adjuvant Treatment in Operable Breast Cancer. *New Eng. J. Med.* **294**:405-410, Feb. 1976.

13. Penn, Israel: Second Malignant Neoplasms Associated with Immunosuppressive Medications. *CA* **37**:1024-1032, 1976.

14. Hoge, A. F., Bottomley, R. H., Shaw, M. T., Ishmael, D. R.: Adrenalectomy and Oophorectomy Plus Limited Term Chemotherapy in the Treatment of Breast Cancer. In Press, *Cancer Treatment Reports*

15. Hoge, A. F., Bottomley, R. H., Shaw, M. T.: Adrenalectomy with Adjuvant Chemotherapy in Advanced Breast Cancer, *Proc. Am. Soc. Clin. Onc.*, May 1975.

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Lower Gastrointestinal Bleeding

D. M. Gregory, MD

Most causes of lower gastrointestinal bleeding can be identified with standard evaluation. If the cause is not apparent colonoscopy can be diagnostic and therapeutic. In cases with bleeding and known diverticular disease, a significant number can be found to have additional pathology. When diverticulosis is known to be present, one can no longer assume the source of bleeding to be a diverticulum without other confirmatory evidence.

Introduction

One of the more frequent, difficult problems facing the practicing physician is defining the cause and appropriate therapy for lower gastrointestinal bleeding or hemorrhage. Lower gastrointestinal bleeding may present as hematochezia (the passage of fresh blood per rectum), melena (the passage of tarry, black, sticky stool with variable amounts of maroon or red blood interspersed), occult blood in the stool, or as a chronic iron deficiency anemia.

Most often the source of bleeding is identified by proctosigmoidoscopy and barium enema. When these studies are unrevealing, too often the evaluation is aborted and significant pathology is overlooked in early and curable diseases.

Depending upon the severity of bleeding, we have found colonoscopy to be of significant value in the evaluation of otherwise undefined lower gastrointestinal bleeding. This significance has also been reported in several recent studies. [1-4]

The purpose of this paper is to present our approach to the patient with lower gastrointestinal bleeding and demonstrate the value of colonoscopy in the undiagnosed case.

Materials and Methods

Studies were conducted on 42 cases in which colonoscopy was performed for lower gastrointestinal bleeding. Each patient had received a minimum workup consisting of: history, physical examination (including digital examination of rectum), proctosigmoidoscopy, and barium enema. These studies were unrevealing in every case.

Seven additional patients were studied who had documented diverticular disease of the colon with no other apparent cause for the bleeding. This group was not included in the previous 42 cases.

The entire colon was visualized except in a small percentage of patients where the cecum could not be reached due to technical reasons.

Results

In the series of 42 patients with previous normal evaluation, the types of diseases identified and frequency of occurrence are as follows:

Type of Disease Identified	Percent	Total Patients	
Inflammatory bowel disease	3	7	%
Non-specific inflammation	6	14	%
Polyps	3	7	%
Carcinoma	1	2	%
Cleocin-induced colitis	1	2	%
Ischemic colitis	1	2	%
Radiation colitis	1	2	%
Localized ulcer, etiology undetermined	1	2	%
Total positive examinations	17	40	%
Normal examinations	25	60	%
Total examinations	42	100	%

Seventeen patients (40%) of the 42 patients studied had demonstrable pathology. The most frequently demonstrated pathology was a non-specific inflammation of the colon. One case each of ischemic colitis, Cleocin-induced colitis, and radiation colitis was identified; also, three cases of inflammatory bowel disease.

In the seven patients with known diverticular disease, the other pathology identified is as follows;

Types of Disease found in Addition to Diverticulosis	Total-Patients
Carcinoma	1
Polyps	1
Total positive examinations	2
Normal examinations	5
Total examinations	7

In both studies, the most important findings were the identification of early unsuspected carcinomas and benign polyps. These polyps were removed at the time of colonoscopy with an electrocautery snare.

Discussion

When a patient presents with bright red blood in stool, an evaluation should be performed even though the bleeding may be minimal. Careful historical detail should be obtained with emphasis on the presence and character of abdominal pain, change in bowel habits, presence and character of diarrhea, weight loss, past history of medications used such as birth control pills and antibiotics, symptoms of bleeding dyscrasias, characteristics of the bleeding pattern, age of patient, and associated illnesses. The physical examination should stress vital signs and the detection of orthostatic hypotension and pallor in patients with hemorrhage. In addition, the presence of pigmentation or telangectasia of the skin and buccal mucosa, signs of portal hypertension, abdominal bruits, abdominal masses, and abdominal tenderness should be noted. A digital examination of the rectum will often demonstrate the pathology.

In the hemorrhaging patient, the failure to estimate the volume of blood loss and to define the presence of hypovolemia and associated diseases, such as coexisting cardiac and pulmonary diseases, is clearly related to a higher mortality rate. If there are signs of hypovolemia or evidence of continued severe bleeding, intravenous fluids (usually normal saline) should be administered, the patient appropriately crossmatched and transfused, and vital signs monitored.

Diagnostic evaluation in the emergent hemorrhaging patient should include a stat hemogram, blood ura nitrogen, prothrombin time, stool for occult blood, and an electrocardiogram. If there is any consideration of upper gastrointestinal hemorrhage, a nasogastric tube should be placed and aspirated to detect the presence of blood. The absence of blood in the gastric aspirate does not definitely rule out an upper gastrointestinal source, but does suggest this is not the origin of the bleeding.

When the blood is bright red in nature and the patient is stabilized, emergent proctosigmoidoscopy should be performed without prior preparation. Up to 75% of rectal and colonic diseases occur within the reach of a 25 cm proctoscope. The procedure is usually diagnostic. If blood is coming from above the reach of the proctoscope, there are two approaches from which to choose, depending upon the severity of bleeding.

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In the active, severely bleeding patient who will require an emergency laporotomy, selective angiography can be of benefit. [5, 6] Localization of the site of bleedings in dogs has been accomplished with a bleeding rate as low as 0.5 cc/min.[7]

The deterrents to this approach are as follows: it is available only in larger centers; the time required to mobilize and complete the study in an emergent, actively bleeding patient is often unacceptable; the rate of bleeding required to give positive results in man is considerable and many false negatives can be expected; and the procedure has a significant morbidity. If the patient is actively bleeding sufficient to require an emergency laparotomy but can be stabilized, selective angiography is indicated if available. Pre-operative identification of the source of bleeding will significantly decrease the morbidity.

With the outlined approach, the source of bleeding should be identified in greater than 75% of cases. If the patient's diagnosis remains obscure, colonoscopy can be an adjunct to diagnosis; in cases of polyps, it can be therapeutic.

As Teague[1] emphasizes, lower gastrointestinal bleeding without a demonstrable cause is an important indication for colonoscopy. To assume in patients with known diverticular disease that the source is from diverticulum without other confirmatory evidence, one may overlook early and curable diseases. The presence of diverticular disease can distort the normal colonic anatomy sufficient to cause some false negative radiographic studies. Colonoscopy is indicated in patients with diverticular disease and lower gastrointestinal bleeding if no other apparent cause for bleeding has been identified. □

REFERENCE

1. Teague, R. H., Salmon, P. R., Read, A. E., Fiberoptic Examination of the Conon: A Review of 255 Cases. Gut **14:** 139-142, 1973.
2. Waye, M. D., Colonoscopy, Surg C1 NA **52:** 1013-1024, 1972.
3. Williams. C., Muto, T., Examination of the Whole Colon with Fiberoptic Colonoscope. Brit Med J. **III** 278-281, 1972.
4. Wolff, Vl, Shinija, H., Earlier Diagnosis of Cancer of the Colon through Colonic Endoscopy (Colonoscopy). Cancer **34:** 912-931, 1974.
5. Baum, S., Stein, G. N., Musbaum, M., Chait, A., Selective Arteriography in the Diagnosis of Hemorrhage in the Gastrointestinal Tract. RAD, C1 NA **VII:** 131-145, 1969.
6. Reuter, S. R., Bookstein, J. J., Angiographic Localization of Gastrointestinal Bleeding. Gastroenterol **54:** 876-883, 1968.
7. Nusbaum, M., Baum, S., Radiographic Demonstration of Unknown Sites in Gastrointestinal Bleeding. Surg Forum **14:** 374, 1963.

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OSMA JOURNAL / special

On Wine and Urine

WILLIAM O. SMITH, MD*
R. PALMER HOWARD, MD

Urine was used for cosmetics and gunpowder, while ancient doctors "judged" its gross appearance for clinical diagnosis: 19th century technology allowed Richard Bright to turn an old romance into a new science.

"What is man, when you come to think upon him, but a minutely set, ingenious machine for turning, with infinite artfulness, the red wine of Shiraz into urine?" These words were attributed to an Arab in the book, *Seven Gothic Tales,* by the Danish novelist, Isak Dinesen.[1]

True it is that even the best of wines are transformed into common urine in the final analysis. What is this substance, urine, which is looked upon by various men in various ways? Shakespeare in the *Merry Wives of Windsor* alluded to it as "the rankest compound of villainous smell that ever offended nostril." On the other hand, Antoine De Fourcroy, a French chemist, wrote in 1801:[2]

> The urine of man is one of the animal matters that have been the most examined by chemists and of which the examination has at the same time furnished the most singular discoveries to chemistry, and the most useful applications to physiology, as well as the art of healing. This liquid, which commonly inspires men only with contempt and disgust, which is generally ranked amongst vile and repulsive matters has become, in the hands of the chemists, a source of important discoveries and is an object of the history of which we find the most singular disparity between the ideas which are generally formed of it in the world, and the valuable notion which the study of it affords to the physiologist, the physician and the philosopher.

And Homer Smith indicated that urine can form a basis of philosophy.[3]

Urine has captured man's interest for over 3000 years, actually as far back as the written record goes. Sumerian, Babylonian, Hindu and Greek physicians examined the urine for diagnostic and prognostic purposes; the character of the urine is described 182 times in Hippocratic texts.[4] Volumes as thick as those that now contain the whole of quantitative clinical chemistry were devoted to the examination of the urine. A book on kidney disease and the urine published in 1861 allots 89 pages to the

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*Delivered in part at the meeting of the History of Medicine Society of the University of Oklahoma Health Sciences Center on October 23rd, 1975.

kidney, 85 pages to the analysis of healthy urine and 250 pages to the examination of the urine in disease. Even in this century a book devotes 410 pages to the examination of the urine.

Throughout the history of medicine, urine has been utilized as a therapeutic agent either to be taken internally or applied externally. Mention of its use appears in the Egyptian papyri and the Roman writers — Pliny, Galen and Sextus Placitus — recount its use in their time.

It has also been used for cosmetic purposes as in the famous urine baths of the wealthy ladies of France in the time of Boyle. Its use as a mouthwash and dentifrice was common in Roman times, and still may be found among primitive peoples.[5]

In his book, *Arctic Adventure,* an autobiography, Peter Freuchen relates an interesting tale. He attended a dance with an Eskimo girl whom he describes as "lovely." He went with her to her father's house, where he was received as a guest of honor. "The girl dressed," he writes, "and then discovered that she had to reset her long, beautiful hair. She loosened it and it gave me a shock to see it flow straight and black over the floor as she combed it. The sun falling upon it through the window gave it a blue-black look of a raven's wing. I was in an agony of love, and my sailor's heart nearly burst with pride that I should be the one taking her to the dance.

"All might have gone well had she not been so eager to make an impression upon a white man. To prove to me what a remarkably clean girl she was, she hauled out from under the ledge a big pail of human urine used for tanning hides and washing. Carefully she lowered her beautiful hair into the pail and thoroughly shampooed it, while my love cooled and my admiration sank as low as the tide in the English Channel."[6]

History supplies us with many other examples of the unique usefulness of urine. Since urea decomposes into ammonium carbonate, an alkaline salt, it was used in the making of soap and for tanning hides, as well as softening and bleaching wool. The Romans prized the substance so highly for these uses that they had marble seats in the market places so arranged that the urine could be collected in one pool from people coming from all parts of the world. Such a collecting station may still be seen in the ancient Roman port of Ostia. Indeed, so important was urine in Roman economy that the emperor placed a tax upon that collected in the public reservoirs.[5, p 140]

The immense importance of the synthesis of urea by Friedrich Wöhler in 1828 is perhaps not generally appreciated. This was the first organic compound to be synthesized and heralded the rise of synthetic biochemistry and the decline of the concept of vitalism with all of its implications. Little did the young Wöhler realize what he had started that day when he prepared urea from a solution of inorganic ammonium cyanate by simply letting the solution stand for a few days in the sunlight. By breaking down the previous concept of mysterious vital forces in the body metabolism into simple molecular reactions he paved the way for the entire new field of biochemistry.[4, p 13-14]

The quantitative study of urine began in 1655 when van Helmont accurately determined the specific gravity of urine by weighing it in a glass vessel and known to hold a certain weight of rainwater. He noted the dilute nature of urine after ingestion of water and the concentrated nature of the substance excreted after abstention from water or in fever. These observations did much to take the wind out of the sails of the uroscopists, whom we shall discuss in more detail later.

The use of urine in diagnosis and prognosis of disease is of more interest to physicians. Sumerian and Babylonian physicians studied urine relative to its color, consistency, frothiness, presence of clouds, sediments, casts and blood.[4] The Hindu Sanskrit writers several centuries BC recognized the disease diabetes mellitus, which they called "honey urine". They observed that trains of black ants were attracted to the sweet urine; thus insects served as a means of diagnosis, possibly our oldest diagnostic test.[4,7]

During the 12th century the uroscopists, or as they were later called, the piss prophets, became popular.[8] (Figure 1) Uroscopy is the art, if it can be graced by even this term, of making a diagnosis of all types of diseases simply on the basis of gross visual examination of the urine. This practice was particularly widespread during the 12th and 14th centuries, and actually continued until about 1700. It still may be practiced to some extent in remote areas of the world. Uroscopy is also known by other names such as water casting, urine gaz-

THE

PISSE-PROPHET

OR

CERTAINE PISSE POT LECTURES.

Wherein are newly discovered the old fallacies, deceit, and jugling of the Pisse-pot *Science, used by all those (whether Quacks and* Empiricks, or other methodicall Physicians) who pretend knowledge of Diseases, by the Urine, in giving judgement of the same.

By THO. BRIAN, M. P. lately in the Citie of *London*, and now in *Colchester* in ESSEX.

Never heretofore published by any man in the *English* Tongue.

Si populus vult decipi, decipiatur.

LONDON,

Printed by *E. P* for *R. Thrale*, and are to be sold at his shop at the signe of the Crosse-Keyes, at *Pauls* gate

1637

Figure 1. Title page from book by Thomas Brian, 1637.

ing, and urine casting. Those who practiced this technique were called uroscopists, water casters, water jugglers, water judges and, in the 17th century, "piss-prophets."

Actually, during this period of medical history, there were only two techniques for examination of the patient. One of these was gazing at the urine, and the other was feeling the pulse. By this time, however, the classical studies of pulse-feeling were beginning to diminish, as many volumes had already been written concerning the various pulse nuances, and this art had been carried to its highest extreme, particularly by the Chinese. The Hindu physicians had also written volumes concerning the pulse, and presumably had made many diagnoses of bodily ailments merely by palpation of the radial pulse. It is not too surprising then that during this later period of medical history the physicians turned to the other thing easy to observe: that is, the urine.

The practice of uroscopy was done in the following fashion. The patient presented the physician with a specimen of urine which was more highly valued if it were the first specimen passed on awakening. In fact, the patient often did not see the physician but merely sent his urine by page or relative who was known as a pisse-bearer, about which more will be said later. Incidentally, the patient had no difficulty in collecting a urine specimen in those days as it was saved in a pot for a time anyhow. The physician then placed the urine in a specially constructed flask which was known as a matula. (Figure 2) Note that the matula is graduated in inches for the correct determination of the situation of any deposit; and therefore, of its "anatomical significance." Solid contents of the urine were classified, according to depth in the urine, as nubes, enaeoremata, and hypostases. The nubes were related to the head; the enaeoremata, to the

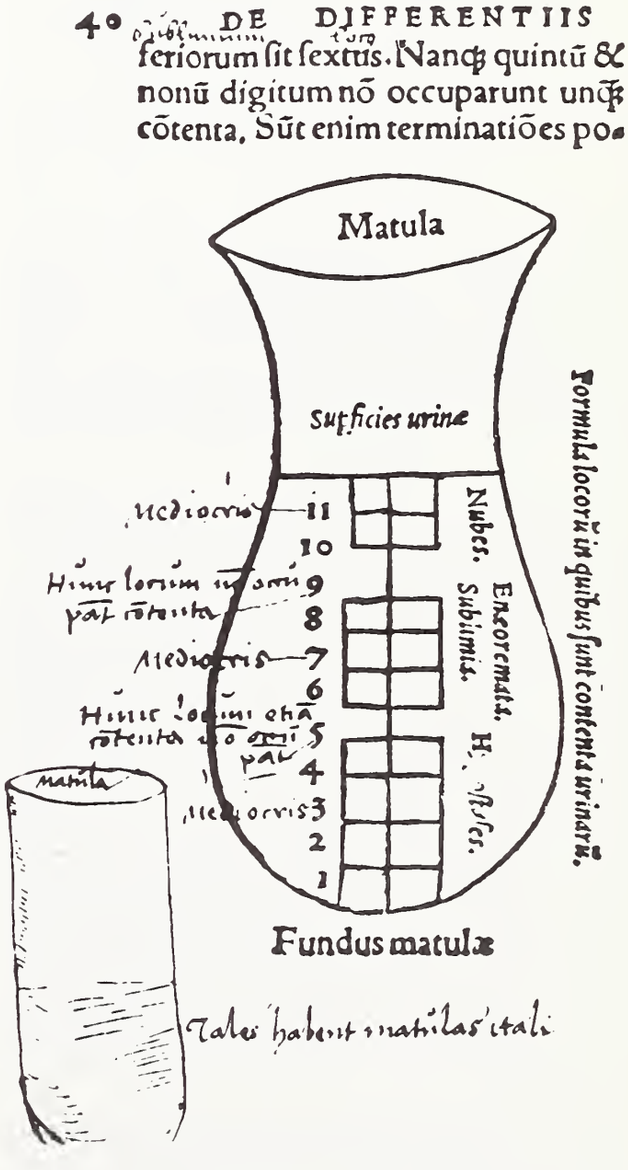


Figure 2. Illustration of a matula from Johannes Actuarius, 13th Century, printed in Basle, 1529, and reproduced by S. S. B. Gilder. [9]

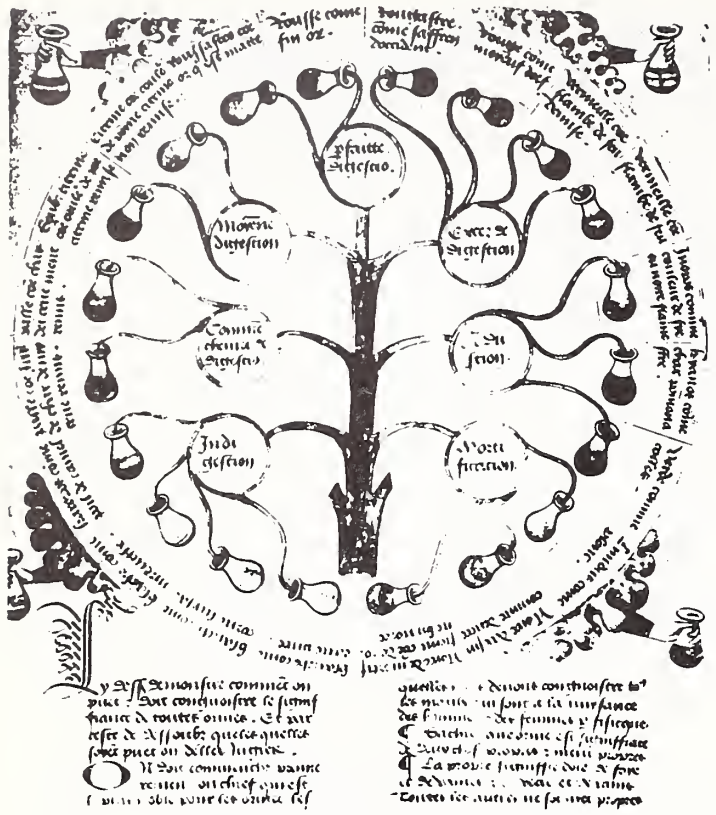


Figure 3. 15th Century uroscopic chart indicating colors and states of "digestion" of the urine from plate IX. [10]

viscera; and the hypostases, to the genito-urinary system. Therefore, sediments noted at these various levels were presumably related to bodily disease in the areas that these signified. In other words, the matula was considered to be an anatomical representation of the body.[9]

The urine was described according to three main qualities: color, consistency, and contents. The color was described through a complete range of twenty to thirty from white to deep black. Figure 3 illustrates a typical color chart.[10] These colors were related to states of coction or digestion as shown in the seven circles. It was thought that red urine appeared in liver disease; and green urine in jaundice, spasm of the genito-urinary tract, or any other spastic condition, including tetanus and hiccoughs. The solid contents at the various levels in the flask were described as sand, ash, grains, bran, blood, pus, fat, chyme, hair, scales, and sperm. Incidentally, both male and female sperm were described by medieval uroscopists.

Examples of diagnoses which presumably could be made were as follows: if the nubes were large and black, this signified headache; grains in the nubes meant rheumatism. If, however, grains were lying some distance below the nubes and they returned only slowly to the top, this indicated the flux of humors descending from the head to the chest. Air bubbles in the urine also supposedly had great significance. Some of the findings seemed to make sense in view of our later understanding of urinary sediments. For instance, it was thought that sand in the urine denoted disease of the kidney or bladder, perhaps stones. Some uroscopists felt that if the urine were red the disease was located in the urinary system. In fact, one famous uroscopist, Gilles de Corbeil, was even more specific about blood in the urine. He distinguished between disease in the bladder and kidney on the basis of the presence of clotted blood in the former.[9]

Another sensible finding was that pus in the urine, together with an evil smell, indicated an ulcer of the bladder or kidneys.

It is interesting to note that the uroscopists believed that the kidneys did not produce urine, but merely strained it, and that the urine itself was produced by the liver. This was done by a process of two digestions, as opposed

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to a single digestion in the gut required for feces. The second digestion was believed to occur in the liver. It was felt that these digestions occurred through a process of coction or heat which was stored in the heart and distributed to the liver. It was felt that this digestion would be favored, therefore, by diseases associated with heat. If the urine showed signs of concentrated digestion at the time of crisis: that is, if it were dark and thick and full of deposit, the prognosis was thought to be favorable. If the digestion during fever were poor, as shown by a pale, thin urine, the prognosis was grave.[7, p 23-24, 9]

It was thought that information obtainable by uroscopy was unlimited. This is attested to in an anonymous fifteenth century manuscript preserved in Cologne as follows:

Maximian, the maistre of phisike,
seeth the urin of the peple;
he can saye to them
whereof they be seke:
of the heedache;
of payne of the eyen,
of the eres;
yf they have tothache,
atte the breste, at the pappes [nipples];
he can hele and cure
dropesye, blody flyxe,
tesyke, normale,
feet, nayles,
fever quartayn and tercian,
of the jaundyse,
whereof God kepe us,
and of all that
that may greve us;
he gyveth counseill for the goute
and for othir seknesses;
he hath many good herbes.[11]

The most famous uroscopist of all was Gilles de Corbeil, a Professor at Paris who had studied at Salerno, and lived from 1140 to 1229. His book entitled *Carmina de urinarum judiciis,* consisting of 352 Latin hexameters, remained a classic on examination of the urine for almost 400 years, somewhat longer than our textbooks last these days. In fact, for hundreds of years after this book was written, no one drew or painted a physician without a urine flask near at hand. This became as much a sign of the craft as the stethoscope is today. Although uroscopy had been practiced as early as the 7th century, Corbeil popularized and brought the art to its greatest development.[12]

Shakespeare refers to uroscopy on at least two occasions. In *King Henry IV – Part II, Act I, Scene 2,* Falstaff says to his page:

"Sirrah, you giant, what says the doctor to my water."

and the page replies:

"He said, sir, the water itself was a good healthy water; but, for the party that owned it, he might have more diseases than he knew for."

Again, in the *Two Gentlemen of Verona,* Act II, Scene 1, Speed says to Valentine:

"—but you are so without these follies, that these follies are within you, and shine through you like the water in a urinal, that not an eye that sees you but is a physician to comment on your malady."

Now, in all fairness, I think we should say that although this business of uroscopy was, for the most part hocus-pocus, as the available knowledge of anatomy and therapeutics was quite limited in those days, the physicians were merely doing the best they could with what they had. The only other diagnostic and prognostic tool available to them at the time was feeling the pulse. Although a great element of divining and superstition entered into this practice, occasionally, no doubt, a correct diagnosis was made of urinary tract disease. In any case, with his elaborate attire, his mysterious matula and apparent wisdom the uroscopist was impressive to patients and maybe benefitted many psychologically. The pronouncements were, no doubt, made with great authority.[4, p 4, 13] (Figure 4)

The earlier students of the urine had stayed rather close to the observations of natural phenomena of the urine. Indeed Galen had warned against an over-interpretation of urine findings, although his own writings naturally enough reflected some speculation of the relation of urine to the strength or weakness of the body humours. As time went on the earlier, partly sensible, urine observations became more and more diluted with nonsense and imagination. Finally, as fact more and more gave place to fancy, the physicians eventually failed to recognize even the few elementary and unmistakable signs of disease detectable by examination of the urine. Astonishingly enough the medieval uroscopists did not taste the urine and therefore missed one real diagnosis they could have made — diabetes mellitus. It was not until 1674 that Thomas Willis rediscovered the sweetness of urine in this disorder. The association of scant urine and dropsy in



Figure 4. Woodcut indicating a physician consulting on two urines presented to him. From *Fasciculus medicinae* by Johannes De Ketham, 1491. [13]

"hardening of the kidneys", originally described by Greco-Roman physicians but overlooked by the uroscopists centuries later, was redescribed long after Corbeil's death.

Incidentally, it is said that when the lord chancellor, Sir Thomas More, was imprisoned in the tower by Henry VIII because he disapproved of Henry's divorce from Katherine and his marriage to Anne Boleyn, he cast his own urine to devine his fate. Despite obtaining a favorable prognosis he was beheaded. [4, p 4]

Now a little more about the pisse-bearer or pisse-messenger. This individual carried a container of urine in a wicker basket to the "physician" with the classic phrase: "Master Doctor, I have brought you a Water and desire your opinion of it." (Figure 4) Then more or less of a contest would begin between messenger and physician. The messenger was instructed by the patient to reveal nothing of the medical history since it was believed that a good physician should be able to see all he needed to know in the urine. If the patient were not satisfied with the uroscopist's opinion he merely had the messenger carry the urine to other physicians until he obtained an opinion most nearly matching his own.

The physicians went out of their way to keep the pisse-bearers happy so that they would sing the doctors praises to the patient or family and insure future cases for the doctor and serve as a source of referrals. Keeping the pisse-bearer happy was apparently best accomplished by splitting the fee with him. [8, p 134]

Since patients sometimes deceived their doctors when they sent them their urine for examination to test their knowledge and skill at uroscopy, it may be pardonable that doctors were instructed how to defend themselves against such trickery. For example, a Spanish physician, Arnald of Villanova, published a treatise in the 13th century listing nineteen precautions which the uroscopist must observe to prevent this kind of deceivery. [14]

Uroscopy finally came under severe fire in the 17th century. Leading the attack against the practice were Sir Thomas Willis and Thomas Brian. The latter in particular, a practicing physician in London and later Essex, revealed the extensive quackery involved in the practice of uroscopy in a book called *The Pisse-Prophet or Certaine Pisse Pot Lectures.* [8] (Figure 1)

Phosphorus was first obtained from an extract of urine and remained the sole source of this element for many years. By the end of the 18th century a total of 14 other inorganic substances had been isolated from urine. A total of at least 106 substances have now been identified in normal urine. Urine as a source of nitrogen supplies us with an amusing anecdote from the Civil War. To quote from Doctor Homer Smith's paper entitled "De Urina:"

"Though phosphate is important in the usefulness of urine as fertilizer, the nitrogen of its urea, ammonia and other compounds is of no less significance in this respect, and urine as a source of nitrogen supplies us with an heroic example of what man in his ingenuity, when hard pressed, can achieve. I refer to the sad plight of Selma, Alabama, during the Civil War. To prepare salt-petre for the manufacture of gun-powder, the Confederates had to resort to all sorts of devices such as leaching the earth from old smokehouses, barns and caves, and making artificial beds of all kinds of nitrogenous refuse, having agents for this purpose in

every town and city. The agent at Selma was particularly energetic and enthusiastic, and advertised in the newspaper as follows:

> The Ladies of Selma are respectfully requested to preserve the chamber lye collected about the premises for the purpose of making nitre. A barrel will be sent around daily to collect it.
>
> John Harrolson
> Agent Nitre Mining Bureau

This came to the attention of a poet in the Confederate Army, who responded lyrically as follows:

He Advertised for Chamber Lye

John Harrolson! John Harrolson! You are a wretched creature.
You've added to this bloody war a new and awful feature.
You'd have us think while every man is bound to be a fighter,
The ladies, bless the dears, should save their P for nitre.

John Harrolson! John Harrolson! Where did you get the notion
To send your barrel 'round the town to gather up the lotion?
We thought the girls had work enough making shirts and kissing,
But you have put the pretty dears to patriotic pissing.

John Harrolson! John Harrolson! Do pray invent a neater
And somewhat more modest mode of making your salt-petre;
For 'tis an awful idea, John, gun-powdery and cranky,
That when a lady lifts her shift she's killing off a Yankee.

This poem was printed on toilet paper and circulated all over the Confederacy, and a copy was smuggled across the line to fall into the hand of an anonymous Yankee poet, who replied:

The Yankee's View Of It

John Harrolson! John Harrolson! We've read in song and story
How women's tears through all the years have moistened fields of glory,
But never was it told before amid such scenes of slaughter
Your Southern beauties dried their tears and went to making water.

No wonder that your boys are brave, who couldn't be a fighter
If every time he fired his gun, he used his sweetheart's nitre;
And vice-versa, what would make a Yankee soldier sadder
Than dodging bullets fired from a pretty woman's bladder?

They say there was a subtle smell that lingered in that powder,
And as the smoke grew thicker and the din of battle louder,
That there was found to this compound one serious objection,
No solder boy could sniff it without having an erection.[4, p 8-9]

The first really scientific correlation of the character of urine with disease of the kidneys must be credited to Sir Richard Bright. This great English clinician and teacher, who lived during the years 1789-1858, boiled the urine from patients with "dropsy" in a spoon over a candle after adding a drop or two of vinegar. He observed a "coagulum" to form in such urine (which, of course, was protein). He then followed these patients to autopsy examination and found gross evidence of kidney disease. He also recognized hematuria (or blood in the urine) in these cases of nephritis.

Strangely enough, however, Doctor Bright went no further in his examination of the urine. Perhaps this was because the medical profession at that time felt that the study of such an excretory product was not proper for a physician. He did send some urines for study to a chemist friend who sent back a "learned report" and there the matter ended. Doctor Bright learned no further secrets from the mysterious urine. So it will always be when clinicians try to get other people to answer questions which they ought to answer themselves.

Doctor Thomas Addis of California contributed much to our knowledge of urinalysis in modern times. He insisted that any clinician who wants to understand his patients with

Bright's disease must examine the urine himself.

And what of the organ that produces this wondrous substance, urine? It was the kidney that freed us from the bonds of an existence in sea water and gave us a free and independent life. Salt and water both had to be conserved and a new kind of kidney was developed to do the job.

The kidney is the main watch-dog of what Claude Bernard called the "milieu interieur". We are exposed to many unfavorable influences in our external environment by which our internal fluids in which we live could be upset violently. The indiscriminate actions of the bowel in absorbing constituents we ingest daily represent a threat to our equilibrium. The kidneys protect us from the catastrophe which would otherwise surely result. The lungs are responsible for maintaining the composition of body fluids only in regard to oxygen and carbon dioxide, and here their duty ends. We are not composed of what our mouths ingest but of what our kidneys retain.

It would seem that the late Homer Smith had a good argument that, in the final analysis and basically speaking, we have been transformed from fish to philosopher because of the kind of urine that we are able to make. [3] □

REFERENCES

1. Dinesan, I.: *Seven Gothic Tales,* New York: Harrison Smith and Robert Haas. 1934, p. 275.
2. DeFourcroy, A. F.: Système des connaissances cliques et de leurs applications aux phénomènes de la nature et de l'art. Paris [1801], Vol. 10, p. 93.
3. Smith, H. W.: *From Fish to Philosopher.* Boston: Little, Brown and Co., 1953.
4. Smith, H. W.: De urina. Kaiser Foundation Medical Bulletin **6:**3, 1958.
5. Bourke, J. G.: *Scatalogic Rites of All Nations.* Washington: W. H. Lowdermilk and Co., 1891, p. 203.
6. Freuchen, P.: *Arctic Adventure.* New York: Halcyon House, 1938, p. 10.
7. Wellcome, H. S.: *The Evolution of Urine Analysis: An Historical Sketch of the Clinical Examination of Urine.* London: Burroughs, Wellcome and Co., 1911, pp. 14-16.
8. Bush, R. B. B.: "Urine is an harlot, or a lier." J A M A **208:**133, 1969.
9. Gilder, S. S. B.: Gilles de Corbeil and the art of uroscopy. First International Congress of Nephrology Geneva / Evian, Sept. 1-4, 1960. Documenta Geigy.
10. Pergens-Maeseyck, E.: Eine Urinschautafel aus Cod. Brux. Nr. 5876 nebst Kommentar. Archiv für Geschichte der Medizin. 1:393-402, 1908.
11. Gessler, J.: "Médecins et chirurgiens d' après les manuels de conversatione du XIVe et du XVe siècle", Janus **36:**316-317, 1932.
12. D'Irsay, S.: The life and works of Gilles de Corbeil. Ann Med Hist **7:**363-378, 1925.
13. Riesman D.: *The Story of Medicine in the Middle Ages.* New York: Paul B. Hoeber, Inc., 1936, p. 328.
14. Marti-Ibanez, F. (ed.): *Henry E. Sigerist on the History of Medicine.* New York: MD Publications, 1960, pp. 134-137.

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MEDIX

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News From The Oklahoma State Department of Health

PENICILLINASE PRODUCING Neisseria Gonorrhoeae — Oklahoma

Five cases of penicillinase producing Neisseria gonorrhoeae (PPNG) have been isolated from patients in Maryland, Iowa, and California. The first of these isolates was discovered in February, 1976, and the latest in July, 1976. A case treated in California remained symptomatic after receiving 4.8 million units of aqueous procaine penicillin G with one gram of probenecid (Benemid). This particular patient was later located in Oklahoma and responded to treatment with spectinomycin on August 27. Three of the five patients, including the Oklahoma patient, named contacts in Southeast Asia. The remaining two cases have been related circumstantially to the same area. Military personnel were involved in four of the five cases; the fifth case, a civilian worked for military while overseas.

This appears to be the first time PPNG has been isolated, and a search for additional cases is being undertaken not only in the United States, but in Southeast Asia as well.

At this time the Oklahoma State Department of Health recommends that *all* patients with gonorrhea be recultured to confirm cure within three to ten days after completion of treatment (test of cure). Organisms recovered from those individuals found positive on test of cure should be surveyed for PPNG.

Questions concerning laboratory aspects of N. Gonorrhoeae should be referred to the Microbiology Section of the State Department of Health Laboratory, telephone (405) 271-5071. Other questions should be addressed to the Venereal Disease Section, telephone (405) 271-4061. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR SEPTEMBER, 1976

DISEASE	September 1976	September 1975	August 1976	Total To Date 1976	1975
Amebiasis	3	3	–	11	30
Brucellosis	–	–	–	7	3
Chickenpox	13	10	9	1587	966
Encephalitis, Infectious	1	–	2	15	47
Gonorrhea (Use Form ODH-228)	1287	1251	1259	10042	9829
Hepatitis, A, B, Unspecified	61	87	57	1038	632
Leptospirosis	–	–	–	1	–
Malaria	–	1	1	2	2
Meningococcal Infections	2	–	1	21	9
Meningitis, Aseptic	–	16	7	18	64
Mumps	18	10	20	700	196
Rabies in Animals	20	11	11	124	90
Rheumatic Fever	–	–	1	12	8
Rocky Mountain Spotted Fever	9	14	15	91	86
Rubella	7	–	6	67	87
Rubella, Congenital Syndrome	–	–	–	–	1
Rubeola	2	6	2	291	135
Salmonellosis	32	44	29	200	188
Shigellosis	11	31	10	163	273
Syphilis, Infectious (Use Form ODH-228)	7	6	7	84	65
Tetanus	–	–	–	–	–
Tuberculosis, New Active	34	17	29	282	242
Tularemia	–	2	–	7	9
Typhoid Fever	–	–	1	1	1
Whooping Cough	1	2	8	19	23

For Consultation Call: (405) 271-4060

Three Perspectives On Health Care Costs

JOHN ALEXANDER McMAHON
President
American Hospital Association

THEODORE COOPER, MD
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U.S. Department of Health,
Education and Welfare

GEORGE B. MORRIS, JR.
Vice-President in Charge
of Industrial Relations
General Motors Corporation

Editor's Note: The articles by Mr. McMahon, Doctor Cooper and Mr. Morris were adapted from remarks made to the Economic Club of Chicago, March 1st, 1976. This article is reproduced here with the permission of the American Medical Association. A similar article by Max H. Parrott, MD, Immediate Past-President of the American Medical Association, was published in the August edition of the Journal of the Oklahoma State Medical Association. The title of Doctor Parrott's article is "Medical Care Costs."

Role of the Health Care Industry in the Health Care Economy

JOHN ALEXANDER McMAHON

Although the subject of the health care economy doesn't lend itself comfortably to one or two sentence summaries, one seems appropriate as a preface to my remarks: the basic issue, as hospitals see it, is one of establishing a balance between the health care services people want and what they are willing to pay.

In the next few minutes I'd like to do three things in support of that concept: first, I want to clarify two terms which are often misused in discussions of the health economy, "charges" and "costs;" second, I want to tell you why costs are going up, and why they will continue to go up; and third, I want you to know what constraints on costs now exist before more constraints are suggested.

CHARGES AND COST

The principal concern about the health care economy is over the high "cost" of health care. *Charges* for health care services are not particularly out of line with charges for other consumer items, as measured by the Consumer Price Index (CPI). Since January, 1972, the CPI has risen about 35 per cent; the health care component of the CPI has risen about 37 per cent. And during the Economic Stabilization Program, when the health industry was subjected to mandatory economic controls, health prices rose at only two-thirds the rate of all consumer prices. The health care component is today rising faster than the CPI as a whole, but that is because items in the hospital marketbasket, such as fuel and malpractice insurance premiums, are rising at an unprecedented rate. I'll have more to say about that later.

The major focus in the health field, then, isn't on charges, or prices. It is on total *costs,* or total expenses, as represented by health insurance premiums, government appropriations for health care, and so on. Total health costs reached 118.5 billion dollars in 1975, as compared to 104 billion in 1974 and 12 billion in 1950. The health industry's share of the Gross

National Product has gone from 4.5% to over 8% in only 25 years.

Total health care cost is, of course, related to increased charges, or prices, as measured by the CPI. But it involves more than that. It involves adding services, improving existing services, and increased use of services. Total costs increase because of demand for new or improved services, and demand is fueled by company, government and private insurance programs that agree to pay for any and all services requested. Under these conditions, total costs must, of necessity, go up.

WHY HOSPITAL COSTS GO UP

There are three major reasons why hospital costs are going up, why the costs for all medical services are going up, and why they will continue to go up.

Labor Intensity: Our industry is, first, very labor intensive. Sixty per cent of our costs go to pay wages and salaries. In most other industries, that figure is closer to 27 percent. We could reduce our labor costs, but to do so we would have to reduce our services. We could eliminate nurses to answer patient calls; we could eliminate lab and radiology technicians; and reduce lab and X-ray services; we could eliminate night and weekend service; we could get rid of the emergency room or the outpatient department; we could do any number of things to cut our labor costs. But what responsible hospital is going to do it, and what community is going to stand by and let it be done?

Marketbasket: The second reason hospital costs are going up is because the cost of everything in the hospital marketbasket, the goods and services we must purchase, is going up. And the cost mix of our marketbasket bears little resemblance to the Cost of Living marketbasket. To operate, we must purchase those goods and services especially hard hit by inflation.

Malpractice insurance is an example. Twelve hospitals here in the Chicago area reported premium increases in 1975 that were up to 400% higher than in 1974. The premiums will be even greater in 1976. In 1974, those 12 hospitals paid $1.60 per patient day for malpractice insurance; in 1975, they paid $6.17 for the same coverage. And some hospitals are paying ten times more for coverage than they did a few years ago.

Increased costs for malpractice insurance, plus increased costs for food, energy, plastics, and the other items in our marketbasket, accounted for 45 percent of hospital cost increases in 1975. And needless to say, the resolution to that problem is out of our hands. The only way to control those costs is to control the suppliers to the health care industry.

Additions to Service: The third major reason for hospital cost increase is improvement of the product through addition of services. Advances in medical technology and technique are made every day, and the advances are costly — intensive care units, disposables for infection control, kidney dialysis, bypass surgery, and so on. So long as advances are made, and so long as patients demand them, the cost of progress will have a decided impact on the health care economy.

In the late 1960's, additions to service accounted for 50% of the increase in hospital costs. Today, these additions account for 25%. If this factor is to be reduced, patients will be denied the advantages of new cures for illness and injury.

EXISTING CONSTRAINTS ON HOSPITALS

There are existing constraints on hospitals that represent attempts to hold down costs. We have health planning and certification of need, which act as capital controls on the industry and provide assurances that major expenditures for services and programs are in line with community health needs. In the past, these controls haven't worked as well as they would have with more interest on the part of business.

Utilization review is a second kind of control to monitor the use of health care facilities. It ensures that the right service is used at the right time for the right condition.

The last constraint, found in a growing number of states, is hospital rate review. To date, these programs have shown no clear impact on reducing hospital costs, but the definitive results aren't all in yet.

Thus there are many constraints on hospital costs. Hospitals believe we should avoid any new constraints until we have fully developed and tested the ones we have.

CONCLUSION

What I've given you for my part of this dis-

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cussion of the health economy is a look at the terminology we use and misuse in talking about costs; the reason for increasing costs; and the efforts made to reduce them. As I said earlier, the issue, in its basic form, is striking a balance between services for the sick and injured and the costs of those services. All of us, in my industry and yours, must join in the discussion to acheive that balance.

I welcome you to the discussion.

The Federal Role in the Economics of Health

THEODORE COOPER, MD

The federal role in the economics of health is an inevitable extension of the overall federal objective in health, which is to improve the health status of the American people. In all the anxiety and debate concerning national health economics and the federal intrusion into health care, one thing needs to be borne in mind: both the health of the American people and the health care system of this country are good and getting better. Life expectancy is increasing. Mortality is going down and more people, notably the poor, are receiving more and better health care than ever before.

In contributing to this progress the Federal Government has helped achieve some remarkable results — in research and manpower development, in the building of facilities and delivery systems, in product safety and control of environmental health hazards, and in the support of programs to pay for, and in numerous instances to directly provide, health care services.

National expectations and aspirations for better health have grown tremendously. We will never reach the level of perfection currently being encouraged by most of us consciously or unconsciously: extended virility; cures for every conceivable illness; instant and undiminishing physical beauty; and immortality. Success in science and medicine always hold out hope, and hope is good.

Yet, we have to realize that health is not only science, it is living, and it is the result of a combination of social, economic, and cultural factors. Viewed in this light then, medical care *per se* is only perhaps a minor contributor to what we call health.

A public demand for perfection, purity, and propriety has driven the notion that rules, regulations, and codification can insure that everything will be right, that individuals will not have to think or act responsibly in their own interest. Not only is this influencing economic policy, but it even carries over to actual health and medical practices.

Compared to total national health spending, the federal dollar share in certain areas of the health care system may be small, perhaps even marginal. But the leverage of the federal establishment is huge. It seems to dominate thinking. In large part this stems from the inability or unwillingness of leaders in the private sector to get together. But it results also from the ability of the federal government to get data and information from different sources and then act on it in a way that individual elements in the private sector could do only with great difficulty.

Within a relatively short span of time, data on health care costs has assumed enormous significance. In fact there can be no question that cost is the single most important force driving health policy decisions. And while the individual practitioner may be relatively unconcerned about the economics of health care at the moment he confronts the needs of his or her patient, the fact is that nothing will exert a more powerful and more destructive influence on the course of health care than the problem of uncontrolled, sharply rising cost. Even in a country that has gotten used to thinking in terms of dollars by the billion, we can not fail to be moved, if not stunned, by what is happening to health care costs.

Probably most of you have heard the figure $118.5 billion as the aggregate cost of providing care and developing health resources in this country. Well, in point of fact that figure, though only a few months out of date, is a long way short of the mark. I admit to shooting at a moving target, but I think a reasonable estimate of the aggregate cost of health this year will be slightly above $135 billion, or nearly $630 per capita.

For the first quarter of 1976, the Consumer Price Index rose at an annualized rate of 3.0 percent, which was, by the way, only about half the rate of increase for the 12-month period ending in March. By contrast, the Index of Medical Care Prices in the first quarter of 1976

rose at an annual rate of 14.2 percent, nearly five times the inflation rate for the whole economy. That, by the way, is why I said a moment ago that we are probably now spending at the rate of $135 billion a year for health care and health resources. And if this pattern does not change, next year the figure will be closer to $155 billion. In that same quarter — January, February, and March of this year — the index of fees charged by physicians and dentists went up at an annualized rate of 14.2 percent, the same as the overall medical care index. But the index of hospital charges rose by 20 percent on an annual basis — half again as fast as health care prices in general and more than six times the rate of increase in the cost of living.

Certainly, at a time of marked inflation in the cost of everything, we have to expect dollar figures to rise. It is really not too meaningful to point out that, in terms of current dollars, Americans are spending $630 per capita for health this year, whereas they spent only $333 in 1970 or only $78.35 in 1950. But when you compare the portion of the gross national product allocated to health from year to year — regardless of the number of dollars involved in any one year — you begin to see the real meaning and impact of rising costs. In 1950, for instance, the United States devoted 4.6 percent of GNP to health; in 1960, 5.2 percent; in 1970 — after the implementation of Medicare and Medicaid — 7.2 percent; last year, 8.3 percent; and according to reasonably reliable projections, by 1980, if not sooner, we will devote 10 percent of the value of all goods and services to paying for health care and developing health resources.

It goes without saying that the pattern of double-digit inflation in the cost of health care and the steadily increasing allocation of the Nation's wealth to pay our collective health care bill cannot be allowed to continue. I say this not out of some moralistic sense of right and wrong, but out of a realistic sense of the social and political impact of uncontrolled growth in the consumption of health dollars. Moreover, I feel very strongly that those of us in the health professions, in the private sector as well as the public, simply have to accept our responsibility to society to put a halt to unwarranted increases in the utilization of health services.

HEW health programs account for over $31 billion of the Department's 1976 budget. Of this amount Medicare will account for $17.5 billion and Medicaid $8.3 billion. The total for fiscal 1977, however, is estimated at $37.5 billion. The increase between 1976 and 1977 of over $6 billion can be attributed almost entirely to increases in the costs of Medicare and Medicaid. This cost increase in a single year for these two programs is greater than the total budget for the entire Public Health Service.

It is clear then that the Federal Government is forced to make hard decisions in order to help contain these mounting costs. This year we are proposing two such changes for consideration. First, is the so-called bloc grant for health. If enacted, this program would enable States to set their own priorities for health spending according to their own individual problems. We would be able to put a cap on the growth rate of Medicaid and other health services programs. We would also be able to reduce Federal bureaucracy significantly.

The second cost-containing proposal is our catastrophic health insurance plan under Medicare. This proposal would achieve two things. First, it would protect all Medicare beneficiaries against bankrupting health care costs. Second, it would limit the amount of increase in charges which physicians and hospitals could make.

But we must consider further steps to help contain costs and assure greater access to services. For example, we must seek additional incentives to change the reimbursement system for health care services so that insurance pays for what patients actually need and not what insurance policies artificially provide for. We must limit allocation of financial resources for capital expansion to projects that are actually needed by communities to provide health care services. We must control utilization of health services in order to assure that people receive and pay only for the care they actually need. We must remedy the present maldistribution of scarce manpower resources, especially family practice physicians, and we must step up our efforts to prevent disease and maintain health. Toward this end we must develop a creative program of health education that will teach patients and the public to make the best use of health care services and to exercise greater responsibility for their own health.

Finally, the Federal role in the economics of health care extends to technology develop-

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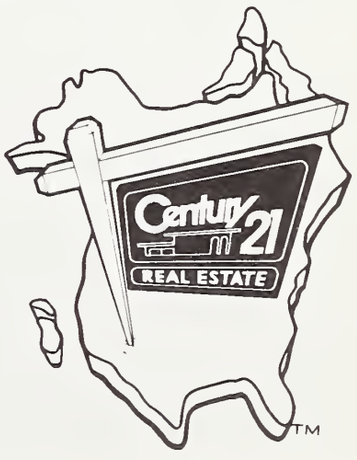
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ment. Here again, it is not possible to infer that advancing technology leads to reduced costs. Often quite the opposite is true simply because the technology may permit medicine to deal with a health problem that was formerly unmanageable and because medical technology frequently tends to involve the use of additional highly skilled manpower. Ultimately, of course, new technological developments, including the development of paraprofessionals and of more efficient systems of delivering care, can reasonably be expected to yield certain economies by making care both less costly and more effective. But as I said earlier, modern, sophisticated medical care is, and will continue to be, expensive, and to assume otherwise — to think that some way can be devised to provide health care as a "free good" — is both naive and dangerous. What is far more likely and thus far more realistic is to assume that health care can be made more accessible, more effective, and more efficient, so that the yield from our tremendous national health expenditures will be significantly greater than it is today.

That is what we in the Federal Government are trying to help accomplish. And I think, indeed I am certain, that we are making progress.

The Impact of Health Care Economics on Business

GEORGE B. MORRIS, JR.

As an employer paying the bill, we are naturally concerned about the persistently continuing increases in health care costs. There is nothing new about this concern. But the feeling about it today among businessmen is the strongest it has ever been. And not only businessmen are concerned — but so are the doctors, the hospital administrators, the insurance carriers — just about everyone with the possible sole exception of the beneficiaries of fully-paid health care coverage.

Why so much concern about increasing health care costs? Because these increasing costs adversely affect our economy. They are not within our control. They keep going up in good times and in bad. And we in business get little credit for the payment of the increasing costs from either employees or the unions that represent them.

Health care coverages are not new for us. We've been offering protection to our employees and their families against the cost of hospital and medical care for over 35 years. We first negotiated these coverages with the unions 25 years ago. In most areas, the coverages were provided through local Blue Cross and Blue Shield plans. At that time, the *total* income of *all* Blue Cross and Blue Shield plans was approximately $455 million. In the calendar year 1975, GM, as one employer, paid $735 million for its hospital, medical, and dental expense coverage for U.S. employees.

Now $735 million is a lot of money. It worked out to more than $1,500 a year for every employee on our roll in 1975. And that is just for health care coverages. When we totaled *all* U.S. benefit costs for 1975, we got a figure of $2.7 *billion,* more than GM's profits in any year in our history. That is an almost incomprehensible figure. To get it to more manageable terms, it means that in 1975 our benefit plans cost us about $5,600 per employee *or about $575 for every GM car and truck sold.*

Of course, our health care coverages have improved, with resulting increases in costs, since our first benefit plan negotiations in 1950. But those improvements do not account for the heavy increases in our health care costs.

For example, our October 1975 fiscal year rate increase raised our annual health care costs an estimated $123 million — over 21% — which was by far the largest single dollar increase in our history. Only about $15 million of that total represented improved benefits — the lion's share of the increase, $108 million, resulted from increased utilization and higher prices. As a result, we estimate that our costs in the 1976 automobile model year (September, 1975 through August, 1976) will total $825 million.

Today, an auto industry employee and his family literally have comprehensive and expensive health care coverages from the cradle to the grave. And the employee pays nothing for these coverages, except for a few minimal copayments here and there.

These coverages include:

- A year's full semi-private hospital care, or two years in an approved nursing home.
- Complete maternity care.

- A wide range of *out-of-hospital* care, including diagnostic and laboratory services, surgery, physical therapy, accidental and medical emergencies, and up to $800 annually for psychiatric services.

- Payment for a wide range of prescription drugs, with the employee paying no more than $2 for each prescription or refill.

- Dental benefits up to $750 per person per year, including examinations, cleanings, fillings, bridges, dentures, and orthodontics. (For most of these services, the patient pays a part of the cost.)

In short, we have one of the best health care packages in the country. It is part of a system where about the only limit on demand is supply. The result — ever increasing costs!

What should we do about it? If I had all the answers to the mind-boggling problem of health care costs in this country today, people would be pounding on my door from every community. I don't even know all the dimensions of the problem, let alone any sure-fire solutions. But there are things we can try.

For one thing, if we are going to have any success in containing health care costs, we must create an awareness of, an interest in and a concern about the cost of health care on the part of both consumers and providers. We should try to rearrange our health care coverages to encourage outpatient care, to minimize hospital stays, and to have the patient share directly in the cost of his health care at the point of receiving provider service.

One approach with promise involves a review of need and cost before the service is performed. In our new dental plan, for example, it is necessary to obtain prior approval of any treatment plan exceeding $100. We've had a few complaints, but the system is generally working well. This pre-treatment screening has also generated "cost awareness" — some employees are telling us that we are getting ripped off. We need more pre-screening in other areas, too, rather than post-audits. We need to assess the situation before the service is rendered. It doesn't help much to find out an appendectomy wasn't needed after the appendix is in a bottle on the shelf.

Another way in which we, as employers, can have an impact on health care costs is by encouraging the *active* participation of well qualified and interested employees on local health care planning agencies, boards, and committees, hospital boards and Blue Cross-Blue Shield plan boards. These employees do not have to be health care experts, but they can make a positive contribution by bringing sound business judgments to bear on issues before the Boards, and by becoming expert at asking not only *what* but *why*. A questioning attitude may not make them popular. But it can stimulate thinking, disturb complacency, encourage ingenuity, and induce imaginative planning, sound policy and cost-effective administration. As members of local health care planning groups, they can consider mergers, sharing of services and equipment, and the question of the number of hospital beds needed — the place where the costs begin. Tough, hardnosed, practical business decisions are urgently needed to offset the "how can you put a price on a human life" syndrome.

As hospital board members, these businessmen can ask "why" there is a need to increase the number of beds at one hospital when beds are empty at other hospitals in the area; they can ask "why" purchase a piece of expensive equipment for one hospital when the same equipment is not being fully utilized at a nearby hospital; they can ask "why" that new hospital wing the medical staff can't live without is really necessary. They can make certain the answers reflect the welfare of the total community, not just their own hospital.

As board members of Blue Cross-Blue Shield plans, they should see that the plans take into full account those who must *pay* the bills as well as those who provide the services and *submit* the bills.

None of these activities will win popularity contests for anyone, but unless and until businessmen speak up strongly for cost containment in the health care field it is not going to happen.

In summary, escalating health care costs have a strong adverse impact on business. We should:

- Reexamine our health care coverages to see if we are contributing to the problem by their design, and if so, take steps to correct it.

- Take an active, positive, cost-conscious role in community organizations which deal with costs at their source, such as local health planning agencies and hospital boards, and

- Demand that our health care carriers

(whether insurance company or Blue Cross-Blue Shield plan) make cost containment one of their top priorities.

I'm told that the health care experts predict annual increases in costs exceeding 10% for some time to come. Have you figured out what that will mean to your organization in the next decade — even if there are no increases in your benefits? In our organization the impact is staggering. I'd like to be part of a group to prove the experts wrong. I invite you to join me. □

OURS Plan Approved

All of the principal parties have now approved Oklahoma's one-year utilization review demonstration project and funding of the program is expected to begin within the next two or three weeks.

After a long delay, apparently all the necessary parties have approved the Oklahoma Utilization Review System (OURS), and the state developed alternative to HEW's utilization review regulations should be in force within the next few months. The recent decision by the Medicaid division of HEW to fund the project clears the way for employment of the necessary employees and the program will soon begin "gearing up." Approximately two or three months will be required before OURS can be fully operational.

The OURS project which began nearly two years ago, is an alternative to the original utilization review regulations handed down by HEW in November of 1974. Since that time, the AMA has successfully challenged parts of those regulations and HEW has issued new ones which are now in effect. The OURS plan, however, is substantially different from the HEW guidelines.

According to a grant request to HEW, the purpose of the OURS project is, "To establish that an objective and reliable retrospective audit system for hospital utilization review can be designed . . . for the purpose of problem identification, and that statewide and/or regional peer group supervision can effectuate expeditious problem solving of a permanent nature." What it all means is that the project will selectively reward institutions which meet certain standards by waiving or relaxing their review requirements. Hospitals that fail to comply with acceptable performance standards will be more strictly reviewed.

Under OURS, computer screening will be conducted to evaluate every hospital in Oklahoma for such things as length of stay, use of ancillary services, charges per day and the number of previous Medicare and Medicaid denials.

If a hospital meets the standards of the program, its internal utilization review will consist primarily of meeting only the reporting requirements and it will require a minimum amount of physician-time. However, hospitals which do not meet the standards of the program will face more stringent review requirements which will in turn require more of the physician's time.

All hospitals will be re-evaluated each quarter by a regional review team made up of nine physicians. If a hospital in the region "fails" the review in any given quarter, it will be notified accordingly and will be given an additional three months to correct the deficiencies.

The OURS plan was written because approximately 40 rural hospitals in Oklahoma could not meet the original utilization review regulations handed down by HEW. Under the HEW plan these hospitals would have been forced to close their doors.

The one-year demonstration project will be administered by the Oklahoma Foundation for Peer Review, Inc., a foundation created by the state's physicians. The OURS project has been endorsed by the Oklahoma State Medical Association, the Oklahoma Osteopathic Association and the Oklahoma Hospital Association. □

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Medix Broadcast Schedule Announced

Medix, a public-affairs television series on medicine and health, has announced its broadcast schedule through the first of the year. The series of programs is aired weekly in Oklahoma City on KWTV, Channel 9. It is broadcast in cooperation with the Los Angeles County Medical Association and co-sponsored in Oklahoma City by the Oklahoma State Medical Association and the Oklahoma County Medical Society.

The series was awarded the Broadcast Media Award for Community Services Programs in a national competition organized by San Francisco State College.

Each program and a brief description is listed below. Air-time is 1:30 p.m.

NOVEMBER 20th, 1976
"STRIKE BACK AT STROKES" — The third largest cause of death in the United States is stroke. Host Mario Machado and experts show the audience what a stroke is and how it may be prevented. The newest techniques for rehabilitating stroke patients is demonstrated including a Neuromuscular Assist Device which enables many paralyzed patients to walk. Several stroke victims tell how this affliction has affected their lives.

NOVEMBER 27th, 1976
"BIO-FEEDBACK; WAVES OF THE FUTURE" — Host Mario Machado has his brain waves tested on this film report about bio-feedback. Bio-feedback is the technique of recognizing and employing brainwaves to control many voluntary and involuntary body functions. Doctor Barbara Brown, a leading authority in bio-feedback, and patients show how bio-feedback can be used as therapy for migraine headaches, epilepsy, insomnia, back pain and paralysis.

DECEMBER 4th, 1976
"CRIB DEATH: THIEF IN THE NIGHT" — *Medix* profiles four families who have lost their children to Sudden Infant Death Syndrome. Although SIDS is the leading cause of death in infants one month to one year old, researchers still don't know its exact cause. How to deal with the initial guilt, fear, and ignorance is answered by the parents and by the doctors, coroner's investigator and social worker/health

nurse team who are the first ones to contact parents after a SIDS death. Doctor Joan Hodgeman tells of research with newborn babies so that one day SIDS will be a predictable and preventable disease.

DECEMBER 11th, 1976
"BREATHING MADE HARD" — Filmed vignettes of emphysema sufferers show how this suffocating disease destroys its victims, and how it can be prevented. In this report produced in cooperation with the Emphysema Foundation of Los Angeles, host Mario Machado takes an on-the-air respiratory test and learns that his lungs are healthier than those of a 19 year-old girl who smokes.

DECEMBER 18th, 1976
"FIRST AID, SECOND NATURE" — Viewers are quizzed on how they would react to common emergencies and on their knowledge of basic first-aid techniques. Situations such as an accidental poisoning, an auto accident, a bad fall, and a heart attack are staged and viewers asked how they would respond.

DECEMBER 25th, 1976
"IF ATTACKED . . ." — With crimes of violence on the increase, no one is immune from attack. *Medix* focuses on the ways to avoid attack, and what to do if attacked. Sheriff's Department deputies demonstrate simple movements to escape an assailant and slow motion film narrated by black-belt champion, Chuck Norris, compares the self defense aspects of karate, kung-fu and judo. □

Face Lift For First Aid Station

For more than ten years, the Oklahoma State Medical Association has been the principal co-sponsor of a First Aid Station at the Oklahoma State Capitol. In 1977, the OSMA will again cosponsor the project, although its organization has been changed substantially in order to make it more efficient and more valuable to the senators, representatives and capitol employees it serves.

This year for the first time the Oklahoma City Area Hospital Council will participate in this project which was one of the first of its kind in the nation. As always, the OSMA will be responsible for staffing the station through its members. Also responsible for providing staff personnel at the station are the Oklahoma State Nurses' Association and the Oklahoma Osteopathic Association.

All equipment and medication needs will be provided by the Hospital Council through its members hospitals.

Because of the strict controls being placed on sample drugs of all types, in the past few years it has become increasingly difficult to stock the station with all of the necessary medications. Since the beginning of the project, nearly all medications have been provided by pharmaceutical companies at no charge to the association.

With the changes in the regulations governing the dispensing of sample drugs, the OSMA has found it increasingly difficult to properly provide for the needs of the First Aid Station and an increasing number of medications have been purchased from local pharmacies. The same has proven to be true for the equipment needs of the facility and therefore, the OCAHC was asked to participate beginning in 1977.

During the next session of the Oklahoma Legislature which will convene in early January, 1977, the Hospital Council will provide all medications and equipment required for the five-month session. Not only will the council provide the original medications based upon a list to be compiled by the OSMA, but a representative of the council will also serve as the direct "medications-equipment contact" for physicians volunteering their time as "Doctor of the Day." If a physician needs either medications or equipment not stocked at the facility, he will be able to contact a representative of the council to place the necessary order.

The Hospital Council will also conduct periodic inventories of the medications and equipment. Emergency transportation to one of the local hospitals will be provided by Amcare, central Oklahoma's new emergency medical care system.

The First Aid Station is in operation approximately five months each year during the legislative session which begins in early January and ends in either late May or early June. OSMA members staff the facility except in February when it is staffed by members of the Oklahoma Osteopathic Association. The Oklahoma State Nurses' Association provides nursing personnel throughout the session.

OSMA members will be contacted about the program some time in late November. Interested physicians are urged to volunteer as a "Doctor of the Day." □

Governors and Others Rebuke Credentialing Bill

The members of the Southern Governors Conference have officially told officials of HEW that they oppose implementation of a HEW report entitled "A Proposal for Credentialing Health Manpower" published in June, 1976. The report calls for the establishment of a national certification council for health care personnel and the development of national credentialing standards for the health care profession.

In opposition to the HEW proposal, the Southern Governors Conference adopted the following resolution submitted by Missouri Governor S. Bond.

> "Be It Resolved, that the Southern Governors Conference by this resolution hereby advises the Secretary, Department of Health, Education and Welfare and the Congress of its opposition to the recommendation presented in the 'proposal' and to the methods and procedures suggested to coerce their acceptance."

Closer to home, Francis Waddle, RN, executive director of the Oklahoma Board of Nurse Registration and Nursing Education, told a special legislative committee that her board opposes the proposal for credentialing for several reasons.

Ms. Waddle told the State Legislative Council's Special Committee on Health Care Delivery Systems that the report assumes "if some state or some licensing boards are not doing a good job, then all states and all licensing boards are not doing a good job." She said the report is inconsistent in its findings and its recommendations when it accuses licensing boards of being "formal extensions of state professional associations, and yet HEW has already hosted preliminary discussions with a number of national professional associations to consider a non-governmental system of certification."

Finally, she said, the report is very ambiguous and does not identify specific occupations, though it states "the subcommittee proposed that specific measures be taken to provide a better assurance of competence than under the traditional licensure model."

HEW's proposal would attempt to establish more uniform licensing procedures to be used by the various health professions in the various states. Ms. Waddle said she had recently attended a meeting in Chicago at which Winston Dean of the office of policy development and planning of the assistant secretary of HEW explained the credentialing proposal.

At that meeting, said Ms. Waddle, Dean, who is a member of the subcommittee on Health Manpower Credentialing, claimed there were three major areas in which the present system is deficient. One, the lack of disciplinary action by boards of medical examiners; two, the "automatic" renewal of licenses by paying fees; and three, the influx of foreign educated physicians who are primarily allowed to practice in state institutions under "limited licenses" in a number of states.

Ms. Waddle told the committee that she realized her testimony would be considered by some to be an attempt at "self-preservation." But, she said, the board is very aware of the controversies which involve the licensing processes.

"However, after several years of experience in this area, it is my personal conviction that it could be likened to Thomas Jefferson's comment when he was asked whether democracy was the best form of government and his reply was, 'It may be the worst form of government, but it is better than all of the others'."

State licensing has its limitations, she admitted, but it is better than the other systems which have been proposed.

Comment: This is another example of the federal government's attempt to force everyone and everything into one common mold: What's good for one must be good for all. It is also another example of the federal government's firm belief that it can perform more effectively than the individual states. The facts are to the contrary however. Oklahoma first began licensing dentists in 1890, pharmacists in 1899, osteopathic physicians in 1903, medical doctors in 1908 and nurses in 1909 – it has done so effectively since that time. For the federal government to believe it can perform the duty more effectively for the more than one million persons who would be involved is pure folly. The rationale behind this move toward national credentialing apparently is the belief that some state boards are not doing an effective job. If this is true, those boards should be dealt with individually. There is no reason to force national rules on the majority of states and state boards which are doing their job well, and there is no reason to believe the federal government could do any better. □

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Cardiology Symposium Planned

The John Steele Zink Institute will sponsor a cardiology symposium entitled "Current Concepts in the Management of Coronary Disease" on January 15th, 1977. The symposium will be held at the Hilton Inn, in Tulsa.

Visiting professors will be H. J. C. Swan, MD, PhD, Director of the Department of Cardiology at the Cedars-Sinai Medical Center, Los Angeles; Robert J. Hall, MD, Medical Director of the Texas Heart Institute, Houston; and W. Dudley Johnson, MD, Thoracic and Cardiovascular Surgeon, Milwaukee.

For additional details see next month's *OSMA Journal* or contact Jose R. Medina, MD, FACC, Director of Clinical Cardiology, Hillcrest Medical Center, Utica on the Park, Tulsa, Oklahoma 74104. (918) 584-1351. □

Osteopaths to Self-Insure

The Oklahoma Osteopathic Association will establish its own malpractice insurance company to provide professional liability coverage to its members beginning January 1st, 1977. The announcement was made recently by Bob Jones, OOA Executive Director.

The DO owned insurance company will provide OOA members with an "occurrence" policy which offers both basic coverage of $100,000 per occurrence per physician and an umbrella policy of $1 million. "Tail" insurance for those who have had "claims-made" policies in the past will also be available.

The company will be capitalized for over $1 million using a surplus debenture which will be signed by each participating osteopathic physician. Each participant will be liable for his prorata share of the annual interest which will amount to approximately $100 annually per person.

The new company will be managed by C. L. Frates and Co., the same company which manages the OSMA plan. The move to a captive insurance company was approved in the face of increasing premiums asked by private carriers.

During recent years, osteopaths in Oklahoma have experienced insurance rates much higher than those paid by medical doctors. In some instances, osteopathic physicians were asked to pay as much as $18,000. At the same time, availability of insurance had grown worse and worse.

Before deciding to go self-insured, the OOA's Bureau on Malpractice had studied the problem for over nine months and had investigated many alternatives. One such alternative was a plan under which patients of osteopathic physicians would have been required to pay a $5 fee each year before they would have been treated. This fee would have been used to establish a malpractice pool to pay malpractice judgments against osteopathic physicians.

This plan and others were rejected in favor of the captive insurance company. □

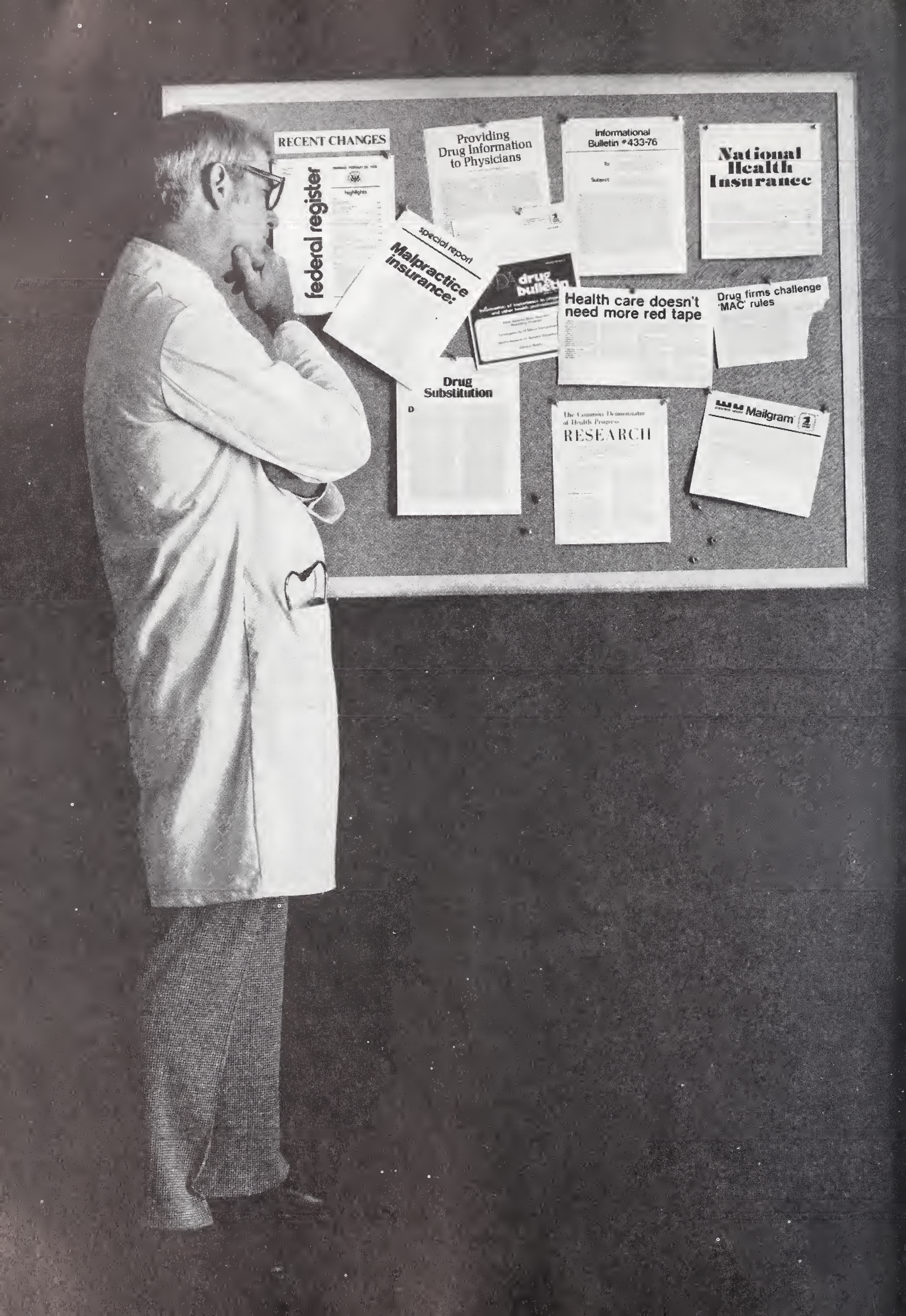
Book Review

Anatomy: A Regional Study of Human Structure — 4th Edition. By Ernest Gardner, MD, Donald J. Gray, MS, PhD, and Ronan O'Rahilly, MSc, MD. W. B. Saunders Co., Philadelphia, 1975, 821 pp, $22.00.

It used to be said of the three big tomes which were the standard textbooks of gross anatomy 30-to-50 years ago that you could hardly make a distinction between their various editions, the only difference perhaps being the fading color of the never-changing illustrations. If you had an old copy from your physician-father it probably would suffice. Things have changed, as this distinguished text by the three authors, of whom two are physicians, testifies. It now appears in its 4th edition and is a favorite in Latin American countries in its Spanish and Portuguese translations. I used to recognize and become acquainted with Mexican freshmen medical students as they studied the book in parks and outdoor cafes all over that country.

The work has many features not present in other anatomy texts. Among them are the incorporation of pertinent modern clinical data which have anatomical bearing and which are also included in the literature listed. Stress is laid on the anatomy of the living as based on radiographic studies; it also contains a short chapter on the history of anatomy, clear, diagrammatic, non over-labeled line drawings, and particularly an excellent bibliography which reveals anatomy as a living discipline that progresses as other basic sciences by research with new tools and new insights. Gen-

(Continued on Page 500)


RECENT CHANGES
federal register
highlights
Providing Drug Information to Physicians
Informational Bulletin #433-76
Re:
Subject:
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all nds of scrutiny. Your control over patient therapy is ing monitored, judged and occasionally abrogated, metimes by unknown third parties.

The worry is that in the wake of this focus, the relaonship between you and your patient will be weakened, ithout offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, gulations or professional custom stipulate that your n-generic prescriptions be filled with the precise prodts you prescribe. But in the last five years, a dozen or ore State laws have been changed, permitting the pharcist in most cases to select a product of the same neric drug to fill any prescription.

Ironically, this dilution of physician control has en place against a background of growing evidence t purportedly equivalent drug products may be inivalent, since neither present drug standards nor their orcement are optimal. In fact, the FDA itself says it not enforced the same standards for hundreds of llow-on" products that it had applied to the original DA approvals. Thus physician control over patient rapy is being eroded with a risk that patients may be osed to drugs of uncertain quality.

The major advertised claim for substitution is reduced scription prices for consumers. Yet no documentation ny significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is ederal regulation designed to cut the Government's g bill by setting price ceilings for drugs dispensed to dicare and Medicaid patients. Unless the prescriber ifies on the prescription that a particular product is lically necessary, the Government intends to pay only he cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

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erally not found in other texts or drawings is the up-dated topography of heart and lungs, pleurae, and pleural fissures. Unique illustrations demonstrate the downward inspiratory bulge of the anterior portions of the diaphragm beneath the heart, which, as the authors point out, on inspiration and erect posture reaches below the level of the xiphisternal joint, not rarely by as much as five centimeters. This can easily be confirmed by radiographic examination with a lead marker on the xiphisternal joint.

Since the authors in the Preface of the 4th edition ask for correction of errors, it may be pointed out that the procedure of gas injection into the perirenal space has been rejected by most surgeons as too dangerous with the possibility of an air embolus and has been replaced by air injection in front of the coccyx. A discussion of the retroperitoneal space and its cranial and caudal connections seems indicated, to understand the anatomy of the spread of retroperitoneal infections. The work can be highly recommended, not only for beginning students, but also for advanced work including postgraduate studies. The price of $22.00 is reasonable. *Ernest Lachman, MD* □

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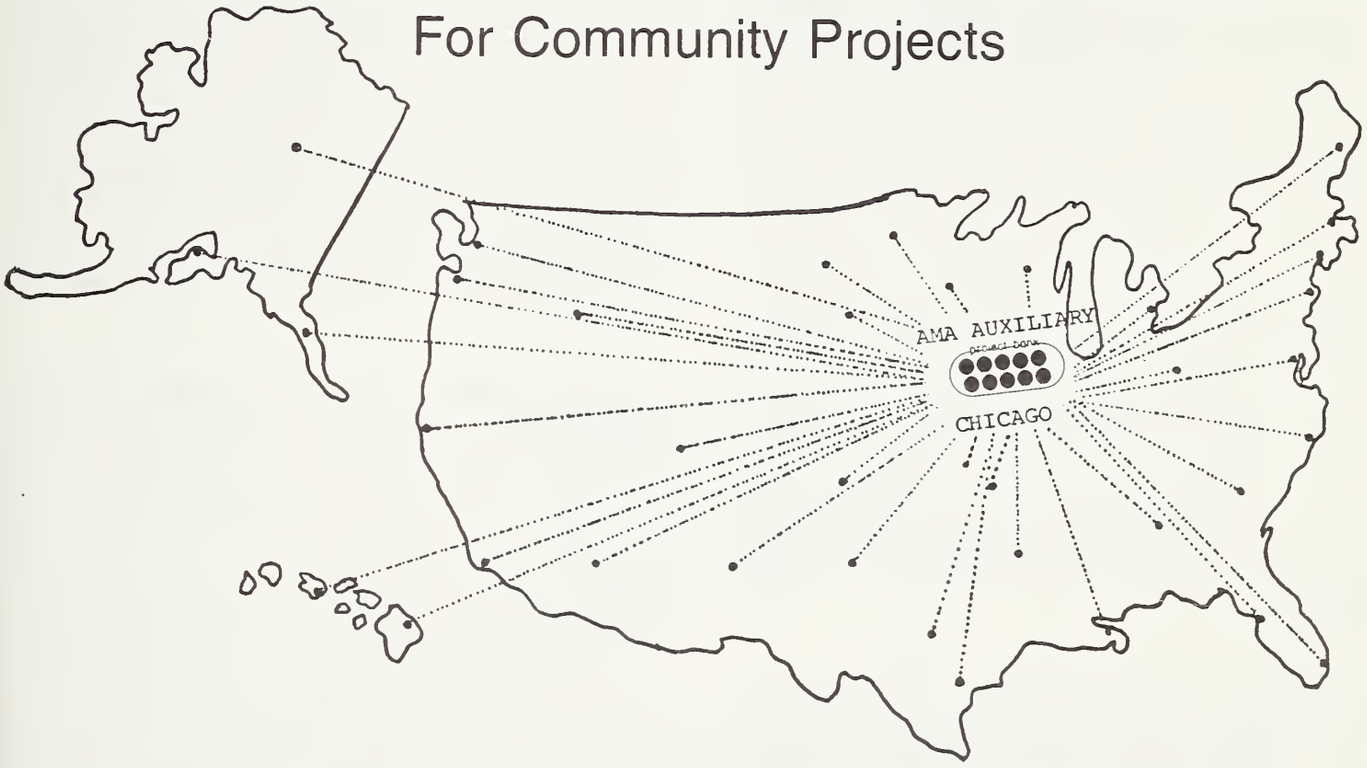
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FROM THE GRASS ROOTS

"Achievements in One Place Shared by Many Others"

The Project Bank is in its second year and is gaining momentum in the state as the auxiliaries become familiar with this new format and make use of its easy accessibility to programs. The Bank is a clearing house for community program ideas and takes the place of the national committees on health related subjects except AMA-ERF, Legislation and Membership.

The Project Bank was designed to fulfill the natural role of the national auxiliary as a resource to state and county auxiliaries in providing program information. Instead of national passing programs down to states and counties, states and counties will be implementing programs based on their own community needs and passing these on to the national auxiliary for sending to other auxiliaries. It will be local initiative stimulated at the national level. The bank has more than 250 tried and proven projects on deposit at the national office to be shared. It is updated twice a year as new projects are sent in to the bank from auxiliaries over the country. As of November 1st, 50 more proven projects will be added to the bank.

The package programs, information on particular subjects of concern, are also available through the Project Bank, as are other resources if a particular desired subject is not on file. This is a very broad spectrum of material made quickly available to auxiliaries and should be of great benefit to them.

There are ten catalogs now in the state available for use by the auxiliaries as they assess their needs and goals in the communities.

Ellen Kimerer, Project Coordinator. □

The American Society of Anesthesiologists and the US Department of Justice will do battle over an antitrust suit filed by the Department over the ASA's publication of a relative value guide. The ASA House of Delegates voted to defend the suit after ASA President John Ditzler, MD, told the society that its chances of winning "are better than 50-50." Three other medical societies have signed consent decrees with the Federal Trade Commission after being charged with antitrust violations over publication of such guides. ASA Delegates decided to defend the lawsuit because to do otherwise would affect "physician capability of self-determination in socioeconomic problems." The cost of the suit has already reached $165,000 and is expected to reach $500,000.

Charges of conspiring to "monopolize health care services" have been filed by five chiropractors against the AMA and 15 other medical organizations and individuals. The antitrust lawsuit was filed in US District Court in Chicago. The suit seeks an injunction to stop actions prohibiting referral of patients to chiropractors, use of x-ray and other hospital facilities, and cooperation between physicians and chiropractors. It also asks full access to hospitals in all states where laws do not prohibit access by chiropractors. The suit seeks a minimum of $1 million a year for ten years from all defendants to operate a "research institute" to promote "inter-professional" programs and to develop a "common lexicon." In addition to the AMA, the suit names as defendants the American Hospital Association, the American College of Surgeons, the American College of Physicians, the Joint Commission on the Accreditation of Hospitals, the American College of Radiology, the American Academy of Orthopaedic Surgeons, the American Osteopathic Association, the American Academy of Physical Medicine and Rehabilitation, the Illinois State Medical Society, the Chicago Medical Society, and the Medical Society of Cook County.

An AMA budget for fiscal year 1977 based on expected revenue of $57,770,000 and expected expenditures of $46,205,000 has been approved by the AMA Board of Trustees. The anticipated favorable balance will enable the AMA to place $11,565,000 in reserve, a policy reaffirmed by the House of Delegates at the 1975 Annual Convention. Spending will be spread among the six missions of the AMA Plan as follows: Scientific Policy and Information, $15,547,000; Promote the Effective Delivery of Care, $3,360,000; Assure and Continue to Improve the Quality of Medical Care, $8,146,000; Represent the Medical Profession, $6,265,000; Strengthen Organized Medicine, $5,524,000; and Internal Support Service $5,863,000. Scheduled for the contingency fund is $1,500,000.

A 30 per cent premium reduction for the OSMA sponsored group life insurance plan has been announced by the plan's administrator, the OSMA Qualified Plan Service Co. The premium reduction announcement comes one year after a nine per cent reduction which was announced in 1975. These reductions make the OSMA plan, one of the finest available anywhere, also one of the least expensive. Physicians interested in the plan are encouraged to contact the OSMA Qualified Plan Service Co., 1480 First National Center, Oklahoma City, Oklahoma 73102. (405) 232-2717. Special plans are also available for administrative assistants, medical assistants, and other office personnel.

Nearly 2,000 Medical Update placards have been distributed to physicians' offices throughout the state. The project is sponsored by the OSMA Council on Professional and Public Relations and is designed to place pertinent information about the medical profession at the fingertips of your patients. The placard can be used either as a counter display or it can be hung on a wall in the office. It has space for three brochures — the first three provided by the OSMA deal with malpractice insurance, national health insurance and physician advertising. If you have not received your Medical Update placard or if additional placards are needed you should write: Medical Update Series, Oklahoma State Medical Association, 601 N.W. Expressway, Oklahoma City, Oklahoma 73118. All materials will be provided free of charge. □

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(Cover Art by William Cason)



The one the patient takes is never tested.

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of The Journal and the

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extend to you and your loved ones

our best wishes for

A Joyous Holiday and

A Happy New Year.



It makes you wonder where they get their mandate and their information.

For the last 20 years or so, members of Congress have been delving in the affairs of medicine as if they had been instructed by some higher power (higher than everyone but Congressmen) to change, remodel, overhaul, alter and otherwise bring our medical system to its knees; the same system which has evolved over more than a 200-year period into the most sophisticated and efficient system in the world; the same medical system which is commonly championed as the model for all others; the same system which is responsible for more advanced technology and more life saving techniques than all others combined. Who or what gives them the right?

As a result of this mistaken and indeed nonexistent mandate, both the medical profession and our patients are now shackled with a Medicaid and Medicare system which has developed into an expensive nightmare — just as we predicted it would. Washington only now realizes the tremendous mistake it made when it forced these governmental schemes upon us and its answer, of course, is to blame the medical profession. Government developed the system, sold it to the people by grossly underestimating its cost and now wishes to place the blame at the feet of the very people who warned years ago that it would fail to perform as promised.

As a result of this mistaken and nonexistent mandate, both the medical profession and our patients are now shackled with a highly complicated, federally-controlled planning mechanism through which the federal government will now be able to tell us when, where and how we will be able to expand our medical facilities. The federal bureaucrats gave this measure a fairly innocuous name — PL 93-641; the AMA calls it the most potentially dangerous piece of legislation ever handed down by Congress.

As a result of this mistaken and nonexistent mandate, both the medical profession and our patients were almost shackled with a utilization review system which would have placed hospital admissions and lengths-of-stay in the hands of a federal auditor over 1,000 miles away; a system which would have forced as many as 50 Oklahoma hospitals to close. Government almost shackled us and it still might.

It makes you wonder where they get their mandate and their information.

Washington tells us we have a tremendous physician maldistribution problem. Washington tells us the cost of medical care has risen so dramatically that the average person can no longer afford to be sick and once sick he can no longer afford to get well. Washington tells us people are dissatisfied with their medical care and the answer to the problem is a mandatory, cradle-to-grave national health care system. Washington tells us they know more about medicine than the 250,000 medical doctors of this nation who graduated from the best medical schools in the world.

The facts tell us different.

The University of Oklahoma Center for Economic and Management Research recently set about finding out just how the people really feel about their doctors, the type of medical care they receive and if the cost of care has reached a point where they can no longer afford it. There were no ulterior motives. The University does not plan to write a NHI bill and it had no input from the medical profession. The goal was to develop hard facts, pure and simple.

This is what they discovered.

*Almost 80 per cent of the people in this state are satisfied with their health.

*Over 91 per cent experience no problems with medical treatment.

*Less than 30 per cent mentioned cost as a problem.

*Almost 75 per cent have a regular family doctor.

*Over 86 per cent are satisfied with their health care.

*Over 70 per cent have health insurance through the private sector.

*Less than one-half favor federally controlled national health insurance.

Granted the people of Oklahoma cannot be absolutely equated with the people from other parts of the country. But recent polls also show that a large majority of all Americans are also satisfied with their medical care. Why then do Washington bureaucrats continue to insist they can better treat and plan for the medical needs of our patients? If they would wake up and take notice of the facts they wouldn't.

In every popularity poll taken recently, doctors have ranked at the top and members of Congress have ranked at the bottom. According to a recent Gallop Poll, 55 per cent of the people believe doctors have very high or high ethical standards. Only 19 per cent of the people feel the same about Senators and only 14 per cent feel the same about Congressmen.

So why do they continue to write rules and regulations to govern the actions of physicians? Why do they feel they know more about medicine than we do? Why do they want to write a national health care plan when they can't properly administer Medicare and Medicaid? Maybe it's because they don't know or don't care.

It makes you wonder!

Orange Williams

OSMA JOURNAL / scientific

Meningitis During the First Three Months of Life: A Review of Cases

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Although emphasis has been directed to meningitis in the neonatal period, relatively little attention has been given to its occurrence and characteristics in infants after the neonatal period. This paper reviews the experience with meningitis in infants from birth to three months of age seen at the Children's Memorial Hospital, University of Oklahoma Health Sciences Center.

It is the purpose of this paper to review our experience with meningitis in infants up to three months of age seen at Children's Memorial Hospital, University of Oklahoma Health Sciences Center, during the ten-year period beginning in 1960. Although meningitis may occur at any age, it is more common during infancy and childhood. In general, its incidence is inversely proportional to age — it is more common in early infancy than in late infancy and childhood. Although emphasis has been directed to meningitis in the neonatal period (0-30 days), little attention has been given to its occurrence and characteristics in infants after the neonatal period. We were interested particularly in symptomatology, etiologic differences between cases occurring in the first month of life and those occurring in the second and third month, and predisposing factors that may influence the incidence and etiology of the disease. Our purpose was to contribute to a better understanding of these aspects so that a prompt diagnosis can be followed by the proper choice of antibiotics even before the causative organism can be established by *in vitro* tests.

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CASE MATERIAL

All cases of bacterial meningitis in infants from birth to 3 months of age at Children's Memorial Hospital from January 1960 to March 1970 were reviewed. Only bacteriologically-proved cases were included. Of the 36 patients studied, 29 were white, 5 were black, 1 was Chinese, and 1 was Indian — a racial distribution similar to that of the hospital population.

The patients were divided into two groups. In Group 1 (n=22) were placed infants with "primary" meningitis, who had no anomalies of the central nervous system (CNS). In Group 2 (n=14) were placed infants with meningitis who had anatomical defects of the CNS such as meningocele, meningomyelocele, or encephalocele.

The patients were further categorized by age (0-30 days, 31-60 days, 61-90 days) and by sex (Table 1). The majority of infants — 22 of the 36 total — were 0-30 days old (ie, neonates) at

TABLE I: Distribution of Meningitis Cases by Age and Sex

	GROUP 1 Age (days)			Subtotal	GROUP 2 Age (days)			Subtotal	TOTAL
	0-30	31-60	61-90		0-30	31-60	61-90		
Male	8	3	2	13	4	2	1	7	20
Female	5	3	1	9	5	2	—	7	16
TOTAL	13	6	3	22	9	4	1	14	36

the onset of meningitis. There were 20 males and 16 females.

RESULTS

Group 1 (Primary) Meningitis Neonates.

Of the 22 infants with primary meningitis, 13 contracted it between 0 and 30 days of life. Table 2 summarizes incidence of low birth weight, maternal complications, complications in hospital, mortality, and sequelae for this and subsequently discussed subgroups. In five of these 13 neonatal cases there were maternal complications (Table 3), and six infants had a low birth weight (<2,500 gm). One case occurred in a premature infant who had no evidence of meningitis when admitted at age 11 days, but who contracted *Escherichia coli* meningitis on the 13th hospital day. The most common syptoms were fever (eight patients), seizures (six patients), irritability and lethargy (four patients), and vomiting and failure to feed (four patients). On admission, six had a bulging fontanelle, four had seizures, two had respiratory distress, and two had fever. Eleven of the 13 had a peripheral leukocyte count of 10,000/cu mm or greater. The causative organisms are shown in Table 4. The organism recovered from the cerebrospinal fluid (CSF) in nine of the 13 Group 1 neonates was a Gram-negative enteric bacillus (*E coli* in six instances and *Klebsiella, Enterobacter*, and *Proteus sp* once each). In three patients the causative organism was also isolated from the blood. Ten developed complications while in the hospital (Table 5); seizures and hydrocephalus were the most common ones. There were five deaths (mortality of 38%), and four of six survivors who were followed had residual neurologic findings. (Table 6)

Older Infants

There were six Group 1 infants between 31 and 60 days of age at onset of meningitis. Two had low birth weights; one of these was the result of a delivery complicated by early rupture of amniotic membranes and maternal amnionitis. This infant was treated with antibiotics for ten days after birth; she developed meningitis due to *E coli* at 35 days of age. Another had *E coli* meningitis at nine days of age and was treated for 12 days, but had another episode due to the same organism at 35 days. The second maternal complication in this subgroup was urinary tract infection in the peripartum period. Otitis media was the focus of infection in one infant.

TABLE 2: INCIDENCE OF LOW BIRTH WEIGHT, MATERNAL COMPLICATIONS, DURING HOSPITALIZATION: MORTALITY, AND SEQUELAE.

	GROUP 1 Infants (n=22) Age (days)				GROUP 2 Infants (n=14) Age (days)				
	0-30	31-60	61-90	Subtotal	0-30	31-60	61-90	Subtotal	TOTAL
Low Birth Weight (2,500 gm)	6	2	1	9	1	0	0	1	10
Maternal Complications	5	2	1	8	5	0	0	5	13
Complication in Hospital*	10	6	2	18	7	2	1	10	28
Mortality	5	2	0	7	5	2	1	8	15
Sequelae	4	1	2	7	3	2	0	5	12

*Numbers include the eight infants who contracted meningitis in the hospital (in Group 1, one neonate; in Group 2, five neonates, one 31- to 60-day-old, and one 61- to 90-day-old infants) and the two instances of therapeutic failure (one Group 1 61- to 90-day-old infant, and one Group 2 neonate).

TABLE 3: MATERNAL COMPLICATIONS ASSOCIATED WITH NEONATAL MENINGITIS:

Maternal Complication	Group 1 Neonates	Group 2 Neonates
Urinary tract infection	1	1
Cesarean section	1 (placenta previa)	1 (previous C/S)
Prolonged labor	1 (44 hrs.)	0
Cord coil asphyxia	1	0
Pre-eclampsia	1	0
Threatened abortion	0	1
Accident, five days before labor	0	1
Fever	0	1
TOTAL:	5	5

There were only three Group 1 infants between 61 and 90 days of age at onset. One had a low birth weight and another had an infected foot in the peripartum period.

The symptomatology in the older Group 1 infants (31 to 90 days old) was similar to but more dramatic than that observed in the neonatal group. Fever and signs of meningeal irritation were more common. However, four had a leukopenic response (peripheral leukocyte count <7,000/cu mm), and five had anemia (Hgb ≤10 gm/100 ml).

There was a dramatic change in causative organisms (Table 4) after the neonatal period. While nine of 13 neonatal cases (69%) were caused by gram negative enteric bacteria, gram negative enteric bacteria caused only two of the nine cases in older infants, and other organisms caused the remainder (78%): *Hemophilus influenzae,* three cases; *Diplococcus pneumoniae,* three cases; and *Neisseria meningitidis,* one case. In all cases of pneumococcal meningitis and in two due to *H influenzae,* the same organism was isolated from the blood, also.

Of the complications which occurred during hospitalization (Table 5), seizures and subdural effusions were the most common ones among the older infants. There were two fatalities among the 31- to 90-day-old infants (mortality of 22%). One occurred one week after discharge. This patient had had *H influenzae* meningitis, which cleared after 15 days of appropriate treatment; 12 days later she spiked a fever and a spinal fluid specimen was cloudy but sterile; however, she was retreated and was observed for three weeks afterwards. One week after discharge, she developed pneumococcal meningitis and died. One patient with *Staphylococcus aureus* meningitis failed to respond to treatment with ampicillin, kanamycin, and cephalothin, but later responded to vancomycin. Of the four survivors who reported for follow-up, three had residual neurologic findings (Table 6).

Group 2 (with CNS defect) Meningitis

There were 14 infants with meningitis associated with local anatomical CNS defects (Table 1). At onset of meningitis, nine were 0 to 30 days old (neonates), four were 31 to 60 days old, and only one was between 61 and 90 days old.

Neonates.

Of the nine Group 2 cases in the 0- to 30-day age group, five involved maternal complications (Table 3). Four infants were results of pregnancies with complications, and the

TABLE 4: CAUSATIVE ORGANISMS

ORGANISM	GROUP 1 Age (days) 0-30	31-60	61-90	Subtotal	GROUP 2 Age (days) 0-30	31-60	61-90	Subtotal	TOTAL
Gram-negative									
Escherichia coli	6	1	0	7	3	2	0	5	12
Pseudomonas aeruginosa	0	0	0	0	3	0	1	4	4
Homophilus influenzae	0	2	1	3	0	1	0	1	4
Klebsiella	1	0	0	1	2	0	0	2	3
Enterobacter	1	1	0	2	0	0	0	0	2
Proteus species	1	0	0	1	0	1	0	1	2
Neisseria meningitidis	0	0	1	1	0	0	0	0	1
Gram-positive									
Diplococcus pneumoniae	0	2	1	3	0	0	0	0	3
Listeria monocytogenes	2	0	0	2	0	0	0	0	2
Staphylococcus aureus									
Coag.-pos.	1	0	0	1	0	0	0	0	1
Coag.-neg.	0	0	0	0	1	0	0	1	1
Streptococcus, group A	1	0	0	1	0	0	0	0	1

TABLE 5: COMPLICATIONS* DURING HOSPITALIZATION

	GROUP 1 Age (days)				GROUP 2 Age (days)				
	0-30	31-60	61-90	Subtotal	0-30	31-60	61-90	Subtotal	TOTAL
Seizures	7	5	1	13	2	1	1	4	17
Hydrocephalus	3	1	—	4	2	2	0	4	8
Subdural effusion	1	3	0	4	0	0	0	0	4
Pneumonia & atelectasis	1	1	1	3	0	0	0	0	3
Hyponatremia	0	0	0	0	1	0	1	2	2
Relapse	1	0	1	2	0	0	0	0	2
Anemia	1	0	0	1	0	0	0	0	1
Dehydration	0	1	0	1	0	0	0	0	1
Ileus	1	0	0	1	0	0	0	0	1
Cylinduria & azotemia	1	0	0	1	0	0	0	0	1
G.I. hemorrhage	0	0	0	0	0	0	0	1	1

*Table shows number of complications; some infants had more than one complication.

mother of the fifth had an automobile accident five days before labor. Only one infant weighed less than 2,500 gm. One-third had bulging fontanelles and nuchal rigidity in addition to the anatomical defect. Eight of the nine neonates had leukocytosis (peripheral leukocyte count ≥10,000/cu mm). As was the case in neonates with primary meningitis, gram negative enteric bacteria were the most common causative organisms (Table 4): *E coli* (three cases), *Pseudomonas aeruginosa* (three cases), and *Klebsiella* (two cases). The remaining case was due to coagulase-negative *S aureus*. In contrast to the much shorter time usually required, three weeks of antibiotic treatment were required before the CSF was again sterile in three of these patients; this reflects the difficulty of treating patients with meningitis associated with an anatomical CNS defect. Five of these neonates did not have meningitis on admission, but subsequently developed it while hospitalized. There were five deaths during hospitalization (mortality of 55%), and one infant died one year later. The three survivors developed hydrocephalus in addition to the myelomeningocele. One moved out of state and could not be followed up further, and two were transferred to nursing homes.

Older infants

There were four Group 2 infants in the 31- to 60 day age group. Two of these had a history of treated neonatal meningitis, were admitted for enlarging head and seizures, and were found to have *E. coli* meningitis. *Proteus sp* and *H influenzae* organisms caused the other two cases. The two survivors both had sequelae; of the two who died, one contracted meningitis in the hospital and died 1½ years later of meningitis and other problems.

The one Group 2 patient in the 61- to 90-day age group was admitted with a CNS defect. There was a history of urinary tract infection and leakage from the meningomyelocele. Culture of the CSF grew *Pseudomonas*. The patient's condition deteriorated progressively, and he died on the 23rd hospital day.

DISCUSSION

Many reviews of meningitis in children exclude a description of the disease either in the neonatal period (our 0- to 30-day age group) or during the first two months of life.[1-3] Yet meningitis is more common in the first month of life than in any succeeding month.[4,5] In a postmortem study of 800 consecutive neonatal deaths, Cruickshank[6] noted meningitis in 4.1%. Groover and associates[7] reported an incidence of neonatal meningitis of 0.4 per 1,000 live births. Overall[5] recently reported on a study of neonatal meningitis from the National Collaborative Perinatal Research Study.

TABLE 6: SEQUELAE* AMONG GROUP I INFANTS

SEQUELA	Age (days) 0-30	31-60	61-90	TOTAL
Hydrocephalus	3	0	0	3
Developmental retardation	2	1	0	3
Relapse/Recurrence	1	0	1	2
Strabismus	1	1	0	2
Diabetes Insipidus	1	0	0	1
Blindness	1	0	0	1
Seizure, infantile	1	0	0	1
Cerebral hypoplasia	0	1	0	1
Arrested hydrocephalus	0	0	1	1

*Table shows number of sequelae; some infants had more than one sequela.

Twenty-five cases of neonatal meningitis were identified among 54,535 live births, which is an incidence of 0.46 per 1,000. In virtually all reported series of meningitis in this age group, including those from large medical centers, the mortality has ranged from 50% to 90%, and even at present still exceeds 65%.[4]

In this study, an effort was made to analyze the influence of two factors — age and the presence of anatomical defects of the CNS — on the incidence and etiology of meningitis. Neonates were compared to older (31- to 90-day old) infants, and those with primary meningitis (Group 1) to those who had both meningitis and associated anatomical CNS defects (Group 2).

The effects of age on etiology were seen in the finding that meningitis tended to be caused by different organisms in the first month than in the next two months of life. In primary meningitis, more gram negative enteric organisms were isolated from neonates than from older infants (*E coli* was the most common organism); the second and third months of life saw a shift to the more "common" etiologic agents (*H influenzae, D pneumoniae,* and *N meningitidis*). This age-related difference in organisms was not seen, however, if there was an associated CNS anomaly. Among Group 2 infants there was no abrupt change in causative agents after the neonatal period.

TABLE 7: MORTALITY

	Neonates (0-30 days)	Older Infants (31-90 days)	All Infants (0-90 days)
Group 1	38%	22%	32%
Group 2	55%	60%	57%
TOTAL (groups 1 and 2)	45%	36%	42%

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The presence of a CNS anomaly predisposing to meningitis affected the etiologic findings in another way, also. Previous studies from this and other clinics[8, 9] have shown that meningitis associated with CNS defects is not due to the overall most common agents of *H influenzae, D pneumoniae,* and *N meningitidis*. This was true in our series — only one Group 2 patient had meningitis caused by one of these three organisms, while seven patients in Group 1 did.

That meningitis is more common in the first month of life than in any succeeding month[4, 5] was borne out by the results in our series. More cases of meningitis occurred during the first month of life (22 cases) than during the second and third months combined (16 cases). And ten infants, seven of whom were neonates, had low birth weights (six neonates and three older infants with primary meningitis and one neonate with an associated CNS defect). Prematurity is one of the predisposing factors that can play an important role in meningitis.[4] The increased permeability of the meninges of premature neonates to dye suggests that premature infants are more susceptible to meningitis.[10] The decreased mobility of leukocytes, longer latent period for response and poor antibody response, paucity or absence of plasma cells in the bone marrow and lamina propria, failure to localize infection (which leads to systemic dissemination), and delayed appearance of mononuclears at a site of infection, all of which have been demonstrated among neonates and are even more pronounced in premature neonates, contribute to their susceptibility.[11-14] The higher frequency of meningitis caused by gram negative enteric bacteria in neonates, which was corroborated by our series, has been attributed to the non-placental transfer of the high molecular weight lgM, the gram negative bactericidin. Although separated neutrophils have been shown to be capable of engulfing and killing *E coli,* the bactericidal capacity of whole blood has been shown to be deficient in the neonate.[4] Dossett et al[15] suggested that decreased opsonic capacity of the newborn might contribute to this deficiency.

The mortality for the various subgroups in our series is shown in Table 7. In both Groups 1 and 2, mortality was higher among neonates than among older infants. At both age levels, mortality was higher among infants with associated CNS defects than among those with primary meningitis. Our overall mortality in

all infants was 42%, with a mortality of 45% among all neonates. Overall,[5] Groover et al,[7] Ziai and Haggerty,[16] and Yu and Grauaug[17] reported a neonatal mortality of 40% to 75% and a neurologic sequelae rate as high as 72%. Of our cases of primary neonatal meningitis that were followed up, 66% had neurologic sequelae (compared with 75% of primary cases in older infants and 100% of cases in infants of any age with associated CNS defects). These generally high figures reflect in part the inherent difficulty in making an early diagnosis and the resultant delay in therapy. Ziai and Haggerty[16] found no complications among neonates treated by age 2 days.

The vague symptomatology makes this infection hard to diagnose unless one has a high degree of suspicion. However, we found more definite signs and symptoms of CNS involvement than others have.[17-19] Seizures were present in 46% of the cases, fever in 61%, bulging fontanelle in 46%, and nuchal rigidity in 31%. Leukocytosis was present in 77% and anemia in 14%.

To help discover infections early, attempts have been made to correlate neonatal infections with maternal peripartum infection, cord vasculitis, prematurity, premature membrane rupture, duration of active labor, fetal distress, low Apgar score, neutrophils in the gastric aspirate, foul and stained amniotic fluid, and cord bacteremia.[20-25] None of these factors alone could predict definite neonatal infection, and although they may serve to alert the physician to the possibility of infection, they cannot replace the pediatrician's clinical judgment.

Since early treatment is important, it is tempting to administer antibiotics "prophylactically." However, there has been no good evidence to support the propriety of this. High-risk babies should have a work-up for sepsis, be watched carefully, and be given antibiotics only when indicated by clinical judgment,[5, 20] since not all of them develop infections. It is important to carefully examine the gram stain smear of the CSF for the presence of organisms. We demonstrated organisms on direct smear in 50% of cases. In a previous study of *H influenzae* meningitis in this hospital, the gram stain smear of the CSF indicated the correct diagnosis in 41.5% of cases.[26]

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REFERENCES

1. Haggerty RJ, Ziai, M: Acute bacterial meningitis. *Adv Pediat* 13:1, 1964.
2. Smith, ES: Purulent meningitis in infants and children: A review of 46 cases. *J Pediat* **45:**425, 1954.
3. Beveridge, J: Purulent meningitis in infancy and childhood. *Med J Aust* **1:**932, 1954.
4. Riley, HD Jr: Neonatal meningitis. *J Infect Dis* **125:**420-425, 1972.
5. Overall, JC Jr: Neonatal bacterial meningitis. *J Pediat* **76:**499, 1970.
6. Cruickshank, JN: Child life investigations: the causes of neonatal death. Medical Research Council Special Report Series no. 145, His Majesty's Stationery Office, London, 1930. 87p.
7. Groover, RV, Sutherland, JM, Landing, BH: Purulent meningitis of newborn infants. *New Eng J Med* **264:**1115, 1961.
8. Lawton, SB, Austin, RL, Riley, HD Jr: (Abstract, Southern Society for Pediatric Research). *South Med J* **61:**1351, 1968.
9. Jasper, PL, Merrill, RF: Hydrocephalus and myelomeningocoele central nervous system infection. *Amer J Dis Child* **110:**652, 1965.
10. Otila, E: Studies on cerebrospinal fluid in premature infants. *Acta Pediat Scand* **35(suppt 8):**3, 1948.
11. Eitzman, DV, Smith, RT: The nonspecific inflammatory cycle in the neonatal infant. *Amer J Dis Child* **97:**326, 1959.
12. Bridges, RA, Condie, RM, Zak, SJ, et al: The morphologic basis of antibody formation: Development during the neonatal period. *J Lab Clin Med* **53:**331, 1959.
13. Matoth, Y: Phagocytic and ameboid activities of the leukocytes in the newborn infant. *Pediatrics* **9:**748, 1952.
14. Gluck, L, Silverman, WA: Phagocytosis in premature infants. *Pediatrics* **20:**951, 1957.
15. Dossett, JH, Williams, RC, Quie, PG: Studies on interaction of bacteria serum factors and polymorphonuclear leukocytes in mothers and newborns. *Pediatrics* **44:**49, 1969.
16. Ziai, M, Haggerty, RJ: Neonatal meningitis. *New Eng J Med* **259:**314, 1958.
17. Yu, JS, Grauaug, A: Purulent meningitis in the neonatal period. *Arch Dis Child* **38:**391, 1963.
18. Swartz, MH, Dodge, PR: Bacterial meningitis, a review of selected aspects. *New Eng J Med* **272:**725, 1965.
19. Fosson, AR, Fine, RN: Neonatal meningitis. Presentation and discussion of 21 cases. *Clin Pediat* **7:**404, 1968.
20. Pryles, CV, Steg, NL, Nair, S, et al: A controlled study of the influence on the newborn of prolonged rupture of the amniotic membrances and/or infection in the mother. *Pediatrics* 31:608, 1963.
21. Wilson, MG, Armstrong, DH, Nelson, RC, et al: Prolonged rupture of fetal membrances. *Amer J Dis Child* **107:**138, 1964.
22. Albers, WH, Tyler, CW, Boxerbaum, B: Asymptomatic bacteremia in the newborn infant. *J Pediat* **69:**193, 1966.
23. Wilson, MG, Armstrong, D: Inflammation of the umbilical cord and neonatal illness. *Amer J Obstet Gynec* **90:**843, 1964.
24. Alford, CA, Schaefer, J, Blakenship, WJ, et al: A correlative immunologic, microbiologic, and clinical approach to the diagnosis of acute and chronic infections in newborn infants. *New Eng J Med* **277:**438, 1967.
25. Overbach, AM, Daniel, SJ, Cassady, G: Value of umbilical cord histology in management of potential perinatal infection. *J Pediat* **76:**22, 1970.
26. Abello, VB, Riley, HD Jr, Rubio, T: Hemophilus influenzae meningitis analysis of 89 cases. In preparation.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all nds of scrutiny. Your control over patient therapy is ing monitored, judged and occasionally abrogated, metimes by unknown third parties.

The worry is that in the wake of this focus, the rela- nship between you and your patient will be weakened, thout offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, gulations or professional custom stipulate that your n-generic prescriptions be filled with the precise prod- s you prescribe. But in the last five years, a dozen or re State laws have been changed, permitting the phar- cist in most cases to select a product of the same neric drug to fill any prescription.

Ironically, this dilution of physician control has en place against a background of growing evidence t purportedly equivalent drug products may be in- ivalent, since neither present drug standards nor their orcement are optimal. In fact, the FDA itself says it not enforced the same standards for hundreds of llow-on" products that it had applied to the original)A approvals. Thus physician control over patient rapy is being eroded with a risk that patients may be osed to drugs of uncertain quality.

The major advertised claim for substitution is reduced scription prices for consumers. Yet no documentation ny significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is deral regulation designed to cut the Government's g bill by setting price ceilings for drugs dispensed to licare and Medicaid patients. Unless the prescriber ifies on the prescription that a particular product is ically necessary, the Government intends to pay only he cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

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Pneumonia Caused by *Streptococcus pyogenes* (Group A Beta Hemolytic Streptococcus)

A Diagnostic and Therapeutic Challenge

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This is a commonly misdiagnosed pneumonia because there is lack of awareness of some of its special features.

INTRODUCTION

Streptococcus pyogenes is an uncommon cause of bacterial pneumonia, being responsible for 1-5 per cent of cases.[1, 9] It causes pneumonia outbreaks in closed populations such as the military services[2, 3] or during measles and influenza epidemics.[4] However, sporadic cases are occasionally reported.[5] Pneumonia caused by *S. pyogenes* is commonly misdiagnosed and has unusual features that separate it from other pneumonias.[6] Therefore, the following cases and review are reported.

CASE REPORTS

First Patient:

A 13-year-old previously healthy male became ill on February 20 with a sore throat and runny nose. He stayed at home for two days then, feeling better, went back to school on the third day. On the fourth day, he developed fever, chills, dyspnea and emesis. On the fifth day, cough with grayish sputum appeared and his dyspnea became worse. He consulted his family physician who diagnosed pneumonia and prescribed penicillin-V 250 mg p.o. every four hours. On the sixth day, the patient became cyanotic, complained of severe right chest and shoulder pains and was admitted to the hospital.

On admission, he was in marked distress, cyanotic, splinting his right hemithorax and breathing at the rate of 60 per minute. His temperature was 38°C orally, heart rate 120/minute, there were rales in the right lower lung, but signs of consolidation were absent. His arterial blood gases, while receiving oxygen, were: PaO_2 59 mm Hg, $PaCO_2$ 29 mm Hg, and pH 7.45. The CBC showed an hematocrit of 40%, 14,000 WBC/mm^3 with 32% neutrophils (N), 57% band forms and 11% lymphocytes. Chest x-ray revealed bilateral lower lobe infiltrates (Figure-1a). Sputum gram stain showed numerous gram positive cocci in chains (Figure-2). Two sputum and five blood cultures obtained on admission were negative. A presumptive diagnosis of pneumonia caused by *Streptococcus* (Diplococcus) *pneumoniae* was made.

The patient was given aqueous penicillin-G 200,000 units intravenously (IV) every four hours. On the second hospital day, he improved

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FIGURE-1a
Minimal interstitial infiltrates in both lower lung fields.

and became afebrile. On the third day, fever recurred, and on the fourth day, a right pleural effusion was noted (Figure-1b). Thoracentesis obtained 15cc of straw-colored fluid with 3.4 grams/dl. protein, 21 mg/dl. glucose, and 2800 WBC/mm^3 (100% N). Gram stain showed no organisms; aerobic and anaerobic cultures were negative. On the fifth day, penicillin was increased to one million units IV every two hours. Repeated thoracenteses were unsuccessful, and decubitus films showed the effusion to be loculated. Fever persisted for two weeks despite penicillin, but there was slow clinical improvement. Troublesome thoracic and shoulder pains continued, causing the patient to splint his right side.

Chest expansion exercises were initiated on the 15th hospital day, soon after, he became afebrile and was free of pain. When discharged, three weeks after admission, he had completed 17 days of high-dose IV penicillin and had full chest expansion. He went home instructed to take ampicillin one gram p.o. every four hours for 10 days. When seen on the 10th day, his chest x-ray was clear with only a small residual pleural reaction (Figure-1c). An Anti-streptolysin O titer done on the eighth hospital day was 625 Todd units. This was repeated on the 14th and 19th days and found to be 2500 Todd units on both occasions. This, with the sputum gram stain, and clinical and x-ray findings, permitted a diagnosis of pneumonia associated with Streptococcus (Groups A, C or G) infection.[3, 4, 6, 7]

Comments:

Features of this case typical of *S. pyogenes* pulmonary infection are the pleuritic pain, the loculated pleural effusion (which developed despite penicillin therapy), the slow response to therapy and the rising ASO titer. Failure to isolate the organism probably resulted from prior antibiotic therapy.

Second Patient:

A 27-year-old male presented with a four-day history of fever, chills, malaise, nausea, pleuritic pains and cough productive of blood-streaked sputum. Chest x-rays revealed an infiltrate in the left lower lung field. The patient

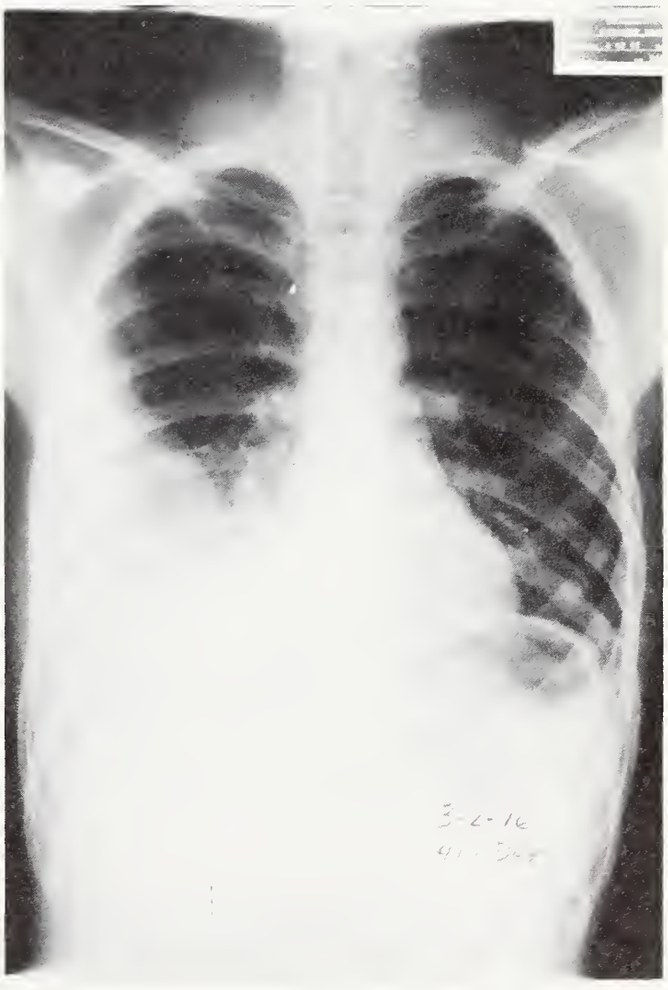


FIGURE-1b
Large pleural effusion on the right and infiltrate on the left now blunting the costophrenic angle.

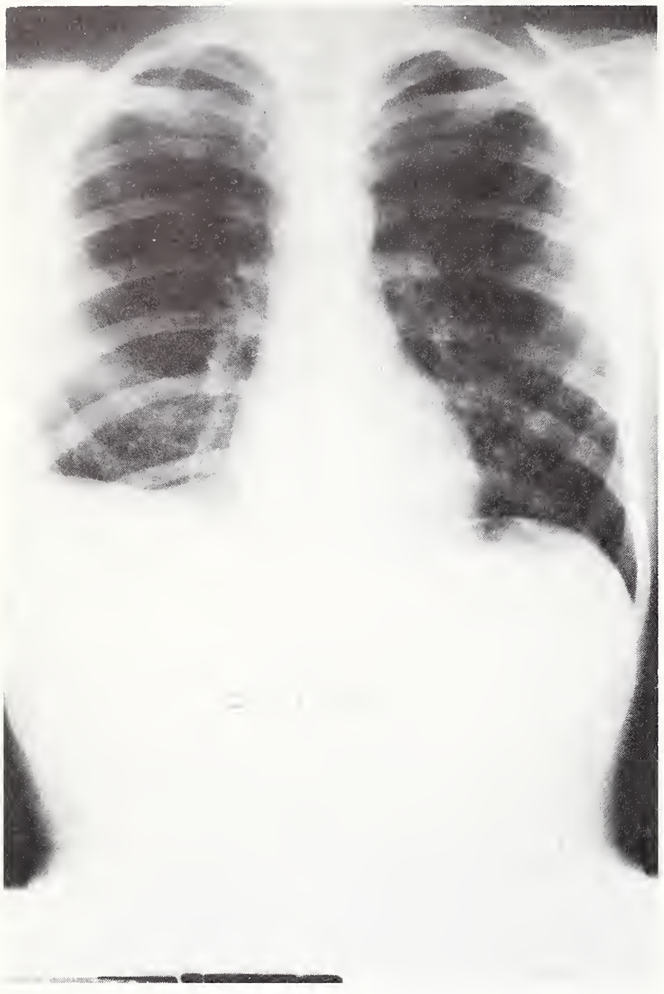


FIGURE-1c
Residual pleural reaction on the right.

left the hospital before receiving treatment, but returned in five days acutely ill, tachypneic, and with a temperature of 39°C. His lungs were clear to auscultation, but x-rays demonstrated cavitary infiltrates in the lingula and the superior segment of the right lower lobe. Sputum cultures grew normal flora, but *S. pyogenes* was grown from the blood cultures. The patient received 12 million units of intravenous penicillin-G daily for two weeks. He slowly improved and was discharged, to continue penicillin-V for an additional week. Eight days after discharge, chest x-ray demonstrated only a small area of residual reaction in the right lung.

Comments:

The bloody sputum and paucity of ausculatory findings reflect the bronchitis and interstitial involvement which are characteristic of *S. pyogenes* pneumonia. Cavitary infiltrates are rare complications of streptococcal pneumonia and probably resulted from the delay in institution of therapy.

Third Patient:

A 51-year-old female presented with a three-day history of malaise, fever, chills, nausea and cough. She appeared acutely ill with tachypnea and a temperature of 39.5°C.

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There were rales over the left chest, but no infiltrates were evident radiographically. Arterial-blood gases revealed severe hypoxemia and hypocarbia. She received intravenous penicillin-G, six million units daily, for two weeks and gradually became afebrile. On the third hospital day, despite penicillin therapy, pleuritic pains developed and a left lower-lobe infiltrate was noted. As she improved clinically, the infiltrate became more extensive and a left pleural effusion appeared. Blood cultures grew *S. pyogenes*. Although the effusion was not drained the patient recovered and was discharged and instructed to take penicillin V after 13 days of hospitalization. A chest x-ray obtained two weeks after discharge was clear of evidence of infection.

Comments:

This patient developed a pulmonary infiltrate and pleural effusion while receiving penicillin and improving clinically. As in the first patient, the effusion disappeared slowly with conservative therapy and drainage was not needed.

DISCUSSION

Bacteriology:

Streptococci are aerobic, gram positive cocci occurring in chains. The cell wall of streptococci consists of three layers. The outer layer contains the pili-like M protein which confers type specificity, according to which Group A Streptococci are divided into some 60 M types. This protein also induces type-specific immunity and is a virulence factor. It inhibits phagocytosis, precipitates fibrin, mediates adherence to epithelial tissues and facilitates multiplication of Streptococci.[8, 13] These unique features may be responsible for the slower response of streptococcal pneumonia to therapy and the higher incidence of pleural effusion or empyema encountered.[9] The middle layer of the cell wall contains the Lancefield group-specific polysaccharide which defines groups A to O. Group A Streptococci (*S. pyogenes*) are the commonest streptococcal human pathogens. Groups A, C and G, besides being very sensitive to penicillin,[11, 14] have several other features in common. They produce beta hemolysis on sheep blood agar, are inhibited by low potency (one unit) bacitracin disks, induce a rise in the ASO titer and are pathogenic to man.[9, 10] Hence, they are difficult to differentiate without the use of grouping sera. This grouping is not routinely performed in most clinical laboratories. Clinically, however, Groups C and G Streptococci are less virulent than Group A and cause fewer infections.[12]

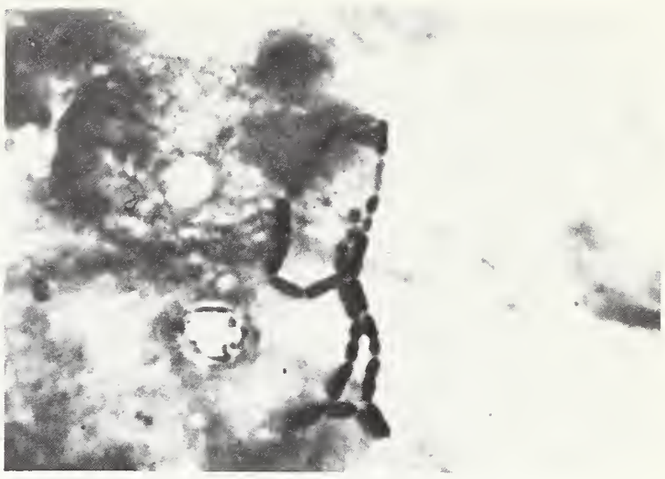


FIGURE-2
Sputum gram stain showing a long chain of gram positive cocci.

Clinical Manifestations:

Although streptococcal pneumonia is frequently unrecognized, it is associated with a high mortality and morbidity. Before penicillin was available, in a series of patients, 16 of 55 (30%), developed empyema and 10 (18%) died.[1] After penicillin, 45 of 95 patients (59%), developed empyema despite adequate penicillin therapy, but none died.[3]

Infection starts with inhalation of contaminated droplets. Aided by the M protein, the streptococci multiply in the lungs, invade the lymphatic channels and precipitate fibrin which results in lymphatic obstruction. This leads to the interstitial edema and pleural effusion so characteristic of streptococcal pneumonia. In spite of therapy, the pleural effusion may develop into an empyema; but more often it is slowly resorbed. The pneumonia is commonly interstitial and involves the lower lobes; however, lobular infiltrates may occur. Lung or pleural abscesses are uncommon complications. An exudative bronchitis with peribronchial inflammation accompanies the infection, resulting in early sputum production which is often blood-tinged.[9]

The onset is acute with fever, chills, cough, sputum, tachypnea and dyspnea. There may be rapid deterioration in spite of antibiotics. In one study, pleuritic chest pain occurred in 78% of patients and was severe enough to cause splinting of the chest. Pharyngitis was present in 61%, but *S. pyogenes* was recovered from the

throat in less than 20% of those with pharyngitis.[3]

Physical examination commonly reveals rales and ronchi. Dullness to percussion and decreased breath sounds are associated with splinting and pleural effusion. However, because the pneumonia is interstitial, signs of consolidation such as egophony and bronchial breathing are usually absent. In spite of frequent involvement of the pleura, friction rubs are rare.[9]

The white blood cell count is elevated, with a shift to the left, in 76% of the cases; the higher the count, the greater the chance that empyema will develop.[3] A rising ASO titer occurs in 97% of the patients and may be the only specific evidence of *S. pyogenes* infection.[3] Early, the chest x-ray shows patchy, interstitial, lower-lobe infiltrates. These are rapidly followed by pleural effusion which may be loculated.[7, 15]

The diagnosis is often overlooked in the sporadic case. Being uncommon, streptococcal pneumonia is not routinely included in the differential diagnosis of bacterial pneumonias. Blood cultures, although diagnostic when positive, grow Streptococci in only 2% of the cases.[3] The sputum gram stain and culture are helpful, but their interpretation is fraught with error. They may suggest the diagnosis, but in themselves are not necessarily diagnostic. A fourfold rise in the ASO titer is significant, but because it may take two to three weeks to rise,[15] it is useful only in retrospect. The specific test that is most often diagnostic is the pleural-fluid culture. Throat cultures alone have no diagnostic value. They are usually negative, and when positive, may merely indicate a carrier state. When the diagnosis is suggested by the clinical picture and confirmed with positive blood-or-pleural-fluid cultures, it is considered definite. A typical clinical course associated with a positive sputum culture or a fourfold rise in the ASO titer is also considered diagnostic, and 68% of patients fall into this less definite group.[3] Thus, in 95 cases of epidemic streptococcal pneumonia, positive cultures were obtained from sputum in 59%, from pleural exudate in 30%, from throat in 15% and from blood in 2%. A rise in the ASO titer occurred in 97%, confirming the diagnosis in those patients who had negative cultures.[3]

Therapy is not based on any controlled clinical trial. The drug of choice is intravenous penicillin-G. The optimal dose is not known, but the tendency is to use 10-40 million units a day. Regardless of dose, the response is usually slow and the febrile course prolonged.[15] The average hospital stay is 2-3 weeks.[15, 3] In the penicillin allergic patient, erythromycin is the drug of choice. Tetracycline has poor activity and should not be used.[14] Repeated thoracentesis of an effusion and drainage of an empyema are indicated.[15] Chest expansion exercises designed to overcome the splinting seem to decrease morbidity and the need for decortication.[3]

Prognosis is good provided adequate therapy is given. Residual pleural reaction without functional derangement is the commonest sequela.[3, 15] The incidence of associated rheumatic fever or glomerulonephritis is very low. Penicillin given as prophylaxis, prevents the spread of the pneumonia in closed populations.[3]

Finally, although uncommon in civilian populations, pneumonia caused by *S. pyogenes* should be considered when a pleural effusion develops despite therapy. Unlike pneumococcal pneumonia, effective treatment requires large doses of penicillin for prolonged periods. If not recognized early, and treated appropriately, it may cause significant morbidity. □

REFERENCES

1. Keefer, C. S., Rantz, L. A., Rammelkamp, C. H.: Hemolytic streptococcal pneumonia and empyema; A study of 55 cases with special reference to treatment. Ann. Int. Med. **14:**1533-1550, 1941.

2. Welch, C. C., Tombridge, T. L., Baker, W. J., Kinney, R. J.: Beta-hemolytic streptococcal pneumonia: Report of an outbreak in a military population. Am. J. Med. Sci. pp. 157-165, 1961.

3. Basiliere, J. L., Bistrong, H. W., Spence, W. J.: Streptococcal pneumonia: Recent outbreaks in military recruit populations. Am. J. Med. **44:**580-589, 1968.

4. Kevy, S. W., Lowe, B. A.: Streptococcal pneumonia and empyema in childhood. New Eng. J. Med. 265, **15:**738-743, 1961.

5. Burmeister, R. W., Overholt, E. L.: Pneumonia caused by hemolytic streptococcus. Arch. Int. Med. **111:**367-375, 1963.

6. McFarland, J. E.: Streptococcic pneumonia. J. Iowa St. Med. Soc. 35, **11:**481-484, 1946.

7. Ziter, F. M.: Large pleural effusions with streptococcal pneumonias. J. Canad. Assoc. Radiol. **20:**185-188, 1969.

8. Hryniewicz, W., Lipinski, B., Jeljaszewicz, J.: Nature of the interaction between M protein of *Streptococcus pyogenes* and fibrinogen. J. of Inf. Dis. 125, **6:**626-629, 1972.

9. Lerner, A. M., Jankauska, K.: The classical bacterial pneumonias. Disease-a-Month. February, 1975.

10. Wannamaker, L. W., Ferrieri, P.: Streptococcal infections — updated. Disease-a-Month. October, 1975.

11. The Medical Letter. Vol. 18, No. 3 (Issue 445). p. 12, 1-30-76.

12. Isenberg, H. D.: Some aspects of basic microbiology of streptococcal disease. NY St. J. Med. pp. 1370-1379, 6-1-68.

13. Kline, B. C.: Pili, plasmids, and microbial virulence. Mayo Clinic Proceedings. **51:**3-5, 1976.

14. Eickhoff, T. C., Finland, M.: *In vitro* susceptibility of group A beta hemolytic streptococci to 18 antibiotics. Am. J. Med. Sci. pp. 261-268, 1965.

15. Thomas, D. F., Glass, J. L., Baisch, B. F.: Management of streptococcal empyema. Ann. of Thoracic Surg. 12, **5:**658-663, 1966.

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OSMA JOURNAL / special

The German Influenza of 1918-19: Personal Recollections and Review of the German Medical Literature of that Period

ERNEST LACHMAN, MD

The US Public Health Service assumes on immunological grounds that the influenza of 1918 was caused by the Swine flu virus. Recent sporadic cases of Swine flu have reawakened our interest in the older devastating outbreak.

The US Public Health Service now states that sporadic cases of Swine flu have occurred recently in this country, having been fatal in one case at Fort Dix, New Jersey. It is also known that the pandemic and devastating flu of 1918-19 was caused by the same agent, ie the Swine flu virus. People who survived that epidemic have neutralizing antibodies in their blood against this virus. Thus the danger exists that this year's expected influenza might be of the same fulminating type as the "Spanish Flu," 1918-19, which involved about one-half of the world population and is supposed to have killed approximately 20 million people.

It seems therefore worthwhile to report one's own subjective impressions of the disease in Germany, although they are limited by the time that has elapsed since then and the absence of personal medical knowledge at that period. The latter deficiency can be compensated for by a study of the German medical literature of 1918-20 which is amply represented in our University of Oklahoma Health Sciences Center Library.

At the time of the beginning of the flu epidemic in 1918, I was just a high school student in a German town with a population of 25,000, but I remember the advent of the "grippe," as we called it, very vividly. My family of four as almost everybody in town was incapacitated by the illness for only a short period, certainly not more than a week. The symptoms were the usual ones of rhinitis, sore throat, bronchitis with cough, severe malaise and fever, accompanied by headache and general joint pain. No other complications occurred in my family. In the beginning of the epidemic this seemed to be the common course. But as time went by, there was a range of severity of the disease from short, mild attacks to fatal complications. A close friend of mine, a healthy, young man of 15 years, died in the isolation ward of the hospital from bronchial pneumonia and pleural complications. I do not think he had been ill for more than a week. It was a terrible, unexpected blow to his family, whose only son he was, and to his friends. One of these brought to the hospital a bottle of French champagne,

which was very precious at the time, and which he himself had received at a family event several years previously and had kept for the celebration of his own graduation.

In spite of these upsetting events, we certainly did not panic. I do not think that this was due to our sturdiness and vitality, but probably can be ascribed to the fact that in the beginning of the epidemic we were hardly aware of the extent of the disease throughout the country and the world at large. The local press, which was the main source of our knowledge of current events, contained very little general information, except for local happenings and probably intentionally underplayed the bad news. Radio, television, and national news magazines did not exist. A number of national journals of high caliber, which my parents subscribed to, concerned themselves only with fiction, educational, and cultural material.

I am not aware that schools or churches were ever closed, but public rallies and sport events were cancelled, yet theater and concerts seem to have gone on. We were all aware that the disease spreads from person to person, mainly by droplet infection in coughing and sneezing, but short of locking oneself in one's room for the whole period, the chance of exposure was ever present, particularly in public places and public conveyances. Home therapy was only symptomatic employing bed rest, fluids, antipyretics and analgesics; sponging and lukewarm wet packs were added in cases of high fever. The disease, if it did not relapse, apparently gave us a short period of immunity as the absence of reinfection in recovered family members, doctors, and nurses indicated. Our physicians allowed us to visit friends laid up with the flu after we had recovered from our own illness.

German newspapers have the peculiar custom of printing in their advertising section black-bordered announcements of the death of an individual, placed there by the family of the deceased, employers, colleagues, friends, fellow members of lodges and clubs, and professional organizations. One could often venture a guess as to the social status of the departed by the size and number of those announcements, which often included an allusion to the length and character of the fatal disease. A eulogy was usually included. By the end of 1918 and in early 1919 these sad witnesses of the ever-spreading epidemic increased rapidly, often containing remarks referring to the suddenness of the fatal outcome and the severity of the unexpected loss.

With growing knowledge of the dangers of the illness, fear and anxiety became progressively worse and were often accompanied by psychosomatic symptoms. As for myself, the reality of death slowly dawned on me as well as the recognition that death struck arbitrarily young and old, men and women, rich and poor, rural and city dwellers. In retrospect it seems strange that the enormous number of fatalities caused by the just-concluded war apparently had made less of an impression on the community and on myself than the immediacy of the fatal epidemic around us.

Coming now to a more objective evaluation of the disease in the German medical literature of that period, I am amazed at the high caliber of the more than 100 articles on the flu dating from 1918 to 1920, which dealt with the history, epidemiology, symptomatology, complications, pathological findings at autopsy, therapy and the questionable cause of the infection. Parenthetically I might add that within the next 10-to-15 years after the epidemic I became personally acquainted with a number of these authors as my university teachers and as colleagues in large teaching hospitals. They generally lived up to the high standard I expected from their publications during the flu period.

As is typical for the German medical literature, a good deal of attention was paid to the interesting history of the flu. It was first described in detail in the 16th century in Italy. The name "influenza" was introduced by Italian physicians who attributed the disease to the unfavorable "influence" of certain constellations of stars and planets.

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The epidemic under discussion began in early 1918 in Madrid where in a short period 100,000 people were struck by the disease. It spread immediately through Spain and Morocco and from there migrated all over western Europe, including Germany, where it became known as the "Spanish disease," or "Spanish Flu." In contrast to this epidemic, the disease generally came from the East and was then named the "Russian Disease" or "Plague." Finally the term "influenza" was used most commonly.

The Germans report that sporadic cases had occurred at the front in the fall of 1916 and 1917. The course of the disease was rather benign during its first wave in the summer of 1918. Generally it lasted less than a week, but the clinical picture changed when it recurred in the fall and winter of that year. The incubation period was one to five days, at which time it started with chills and high fever. In contrast to previous epidemics that struck in winter, this one started in summer.

Originally the Germans attributed the severity of the disease in its later phases to the state of undernourishment of the population, bordering on famine caused by the blockade of Germany. But this was discounted later when well-nourished, muscular individuals between the ages of 15-to-30 years turned out to be the favorite target of the more severe forms of the flu. There is a surprising difference between the statements of the German literature of that period and today's view that older people are particularly endangered. Frequently the German authors point out that older age groups are less threatened because they still harbor some immunity from the previous pandemic of 1889-90. So far no satisfactory explanation has been offered for the predeliction of the flu for physically stronger and healthier individuals. Among hospitalized patients, who of course represented a group characterized by a more severe type of disease and more serious complications, there was an overall mortality of 25 to 50 percent, but no difference in mortality rates between males and females could be observed. In contrast to the present literature, most older authors believed that infants and smaller children represented an especially endangered age group. There is general agreement that the mucosa of the respiratory tract was the portal of entrance for the disease-causing agent.

With German thoroughness every nuance of the clinical picture of the disease with its signs and symptoms is pointed out. In this report the typical course of the influenza of 1918-19 will not be described here since it corresponds in every respect with today's textbook discussions.

It should be repeated here that our interest in the pandemic of 1918-19 rests on the supposition that a coming epidemic of swine flu could be as sweeping and devastating as the one in 1918, which on immunological grounds is assumed to have been caused by the same agent. Thus, a look at the more severe complications of the old epidemic seems indicated. It is inferred in the literature of that period that most of the complications were due to superinfections by pneumo-, strepto-, staphylococci, Klebsiella and particularly *Haemophilus influenzae,* although these organisms were frequently not found at autopsy. A number of authors concluded that the unknown causative agent itself could produce a fatal sepsis. The blood count typically showed leukopenia with relative lymphocytosis. Later, general leukocytosis was ascribed to the bacterial infection. Every epidemic seems to have its peculiar variations. The epidemic of 1918 was characterized by the following complications:

1. Frequent involvement of the respiratory tract with pseudo-membranous tracheitis, double-sided bronchiolitis, lung abscesses, empyema, including interlobar empyema, and on the whole a more fulminating course than in previous epidemics. In small children glottis edema and laryngospasms and fatal or almost-fatal tracheal stenosis were observed. Occasionally a more chronic course extending over several months with bronchiectasis and emphysema, accompanied by bloody sputum and chronic pleuritic changes is reported. These complications combined with chronic subfebrile temperatures seemed to imitate tuberculosis.

2. Cardiac failure and vasomotor collapse were one of the main causes of death in this epidemic and were ascribed to the toxins of the noxious agent.

3. A typical complication that generally does not occur in other flu epidemics was the frequent appearance of encephalitis, which on autopsy was often hemorrhagic and accompanied by peri-vascular infiltrations. It often involved the intra-cerebral nuclei of cranial nerves and also spread to the spinal cord, resulting in an encephalomyelitis. In one case the brain involvement lead to an almost unbelievable hyperpyrexia of 111.2 degrees F for 44.2 degrees C. In most cases of encephalitis the clinical picture was typical with fever, lethargy, and some-

times peripheral rigidity, cranial nerve paralysis and behavioral disorders. Ten years later as house officer I saw a number of cases of Parkinsonism which were a consequence of the epidemic of 1918. Peripheral polyneuritis also was one of the not-too-rare complications.

4. Particularly endangered in this epidemic were pregnant women, women in labor or delivery, and in the puerperium.

In closing this discussion of complications we must state that no organ escaped. In addition to those listed we have to mention involvement of eyes, ears, paranasal sinuses, the gastrointestinal tract with an occasionally typhoid-like picture, the urogenital system with hemorrhagic nephritis, pyelocystitis and prostatic infection, osteomyelitis and septic joints. The skin sometimes showed a scarlatinous exanthema.

A most interesting topic that occupied many authors and scientists was the etiology of the disease. Bacteria of all kinds and particularly the Pfeiffer bacillus now called *Haemophilus influenzae*, were often identified as the causative agents. A somewhat larger school of scientists was inclined to assume a viral cause with frequent bacterial superinfection. In one case an author and his assistant injected themselves with a sterile filtrate from throat smears of patients with flu and both fell ill, one with headaches and rhinitis, the other with chills, fever, lassitude, and joint pains. On the whole the majority of authors seemed more inclined to ascribe the outbreak to an unknown virus. Most outspoken in this respect is Ludwig Fejes of the University Clinic in Budapest. In an article on the etiology of influenza in the "Deutsche Medizinische Wodenschrift" of June 12, 1919, pp. 653-655, he reports that he injected filter-passed fluid from the sputum of flu patients subcutaneously into monkeys where it caused a hemorrhagic sepsis, identified by him as viral in character. He compares the resulting disease with the Swine flu where the virus causes the basic feature, ie a sepsis, while bacilli typical for Swine infection lead to secondary complications. He postulates that the human infection of influenza is viral in character and that the liability to superimposed bacterial infections is due to weakening and loss of resistance of the human organism by the virus. □

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OSMA JOURNAL / special

Oklahoma Physician Manpower Training Commission Increasing Residency Positions with State Funds

C. S. LEWIS, JR., MD

Several publications [1,2,3] have indicated the need for an increased number of physicians to be trained in and for the State of Oklahoma in order to provide adequate health care. The Oklahoma Health Manpower needs were tabulated in a publication by the State Department of Vocational Technical Education in September, 1973[2] and again in July, 1975.[3] These studies have indicated that Oklahoma at that point had approximately 2,500 MD's and 450 DO's and that approximately 900 additional physicians were needed to bring the state up to the national average of physician to population ratio. They estimate that 180 to 200 new physicians per year will be needed in Oklahoma to maintain an adequate number of physicians in the future.

In 1974 the University of Oklahoma College of Medicine graduated 131 medical students. There were, at that time, 85 first-year residecency positions in the State of Oklahoma.[4] It has been documented in the past that approximately 50% of medical student graduates remain in the state but about 80% of residents trained in the area remain in the state!

For these reasons, in 1974 the Oklahoma State Medical Association sponsored a program to educate the general public as well as physicians and legislators to the needs of an increased number of residency training positions for Oklahoma. The legislation was introduced and passed by the Oklahoma State Legislature in the spring of 1975. It was further amended in the spring session of 1976. The 1975 legislation created the Physician Manpower Training Commission, which was appointed by the governor and started operation in July, 1975. Planning is in progress for its third program year to begin July 1, 1977. Current members are: Fred D. Cormack, Chairman, Cherokee, Oklahoma, Jack W. Parrish, MD, Vice-Chairman, Seminole, Oklahoma, Olen D. Berrong, Clinton, Oklahoma, Billy D. Dotter, MD, Okeene, Oklahoma, J. Scott Hickerson, DO, Cleveland, Oklahoma, C. S. Lewis, Jr., MD, Tulsa, Oklahoma, and John D. McCuistion, DO, Madill, Oklahoma.

The Physician Manpower Training Commission has four areas of activity which include the Oklahoma Rural Medical Scholarship Program, the Oklahoma Community Matching Program, the Oklahoma Intern-Resident Program and the Physician Placement Service. The commission has been charged by the Legislature to review manpower data and accredited training programs, provide advice and counsel to hospital training programs, develop criteria to determine training costs, establish criteria for awards to training programs, approve funding levels and provide appropriate staff support.

The Oklahoma Rural Medical Education Loan and Scholarship Fund

This program was created to grant scholarships to qualified students who are residents of the State of Oklahoma who would not otherwise have funds necessary to finance the cost of a program of study leading to the degree of Doctor of Medicine or the degree of Doctor of Osteopathy. The program provides up to $7,000 per year in exchange for an agreement to practice in an Oklahoma community of 7,500 population or less. The loan is forgiven on one-year of service for one-year of scholarship. There is a provision for two-year minimum service. The penalty clause for nonperformance provides for 10% interest on the loan to be repaid in one to four years. Although placed under the jurisdiction of the Physician Manpower Training Commission in 1975, the Rural Medical Scholarship Program has been in operation since 1970 with an increased number of students each year. In the current year there were ten new recipients and a total of 25 in the program. There were 13 in residency training and eight had finished their training and were in practice.

Oklahoma Community Physician Education Scholarship Program

This program was set up "to establish and administer cost-sharing scholarships and loan fund programs which will provide for state assistance in participation with community physicians and scholarship funds which are selected and approved by the commission."[5] The matching fund program is available to any medical student who is a resident of Oklahoma. It provides up to $10,000 per year living costs. The community with whom the student is associated provides up to $5,000 per year matching funds, and up to $5,000 are provided through state funds administered through the Community Matching Scholarship Program. This mechanism provides an opportunity for smaller communities in need of physicians to have an arrangement with a medical student to return to the community by contracting with the student to provide a portion of his living expenses during medical school to be matched by state funds. A three-way contract is signed between the community, the student and the state with agreement by the student to practice in the sponsoring community. The loan forgiveness clause provides for one-year of service for each $5,000 of state funds that are loaned with a two-year minimum. The penalty clause for non-performance is 10% interest on the loan to be repaid in one to four years. The program began in July, 1975, and there were nine participants at that time. The second year started in July, 1976, when twelve new recipients were added. There are currently 20 students in the program and one graduate is in residency training. There are approximately 40 additional communities which have applications in process. It is felt by the Commission that this program has an excellent chance of providing a very good relationship for long-term practice by qualified young physicians in areas of medical need in Oklahoma.

Oklahoma Intern-Resident Cost-Sharing Program

Because of the increased chance of a young physician practicing in the area in which he has taken his postgraduate training,[1] it is felt that this portion of the program may have maximum effectiveness in providing more physicians for Oklahoma in the future. It is the intent of this program to increase the number of internships and residency programs offered throughout Oklahoma through sharing by the state of the costs of such internships and residencies. This program is designed to emphasize primary care physician training. The Legislature defined primary care physicians as those in Internal Medicine, Obstetrics and Gynecology, Pediatrics, Emergency Trauma and Family Practice. Any accredited program may apply for matching funds for residency positions. Fifty percent of the salary of the resident, up to $8,000 per new primary care residency position, is provided. This is contingent on the stipulation that the program making application does not decrease its dollar appropriation but increases the total number of positions. Some development funds are also provided. The number of MD graduates from the University of Oklahoma College of Medicine at Oklahoma City and the University of Oklahoma Tulsa Medical College in Tulsa, which is a third and fourth-year branch program, are expected to produce 159 graduates in 1977 and gradually increase thereafter. Thirty-seven

new residency positions were provided in 1975, and 36 slots in 1976. The amending legislation passed in 1976 indicates that there will be 40 new positions added in both 1977 and 1978. The new positions for the year 1976-77 are divided as follows: Family Practice-31, Internal Medicine-24, OB-GYN-2, Pediatrics-2, and Osteopathic Internships-17. The recommendations for distribution of these funds are made to the Commission by a committee composed of the Dean of the University of Oklahoma College of Medicine, the Dean of the University of Oklahoma Tulsa Medical College and the Dean of the Oklahoma College of Osteopathic Medicine and Surgery. This program will be supportive of the new satellite family practice program which will be started in Enid, Oklahoma, in July, 1977. Other satellite programs are planned in the following years.

Placement Service

This is a service which provides an information clearing house for all Oklahoma communities. It is available without charge to all medical students and physicians both in Oklahoma and outside the state. Current figures indicate that there are 232 practice opportunities with 167 active applicants in 95 communities in Oklahoma.

Cost

The total cost of each program for the current year is: Rural Scholarship Program — $98,250, Community Program — $48,980, Residency Program — $192,000, and Administrative Expense — $24,710, or a grand total of $363,940. The projected costs for 1977 are Rural Scholarship Program - $150,000, Community Program — $274,650, Residency Program — $438,000, Physician Placement — $20,000 and Administrative Expense — $40,500, with a combined total of $923,150.

This approach to providing further postgraduate training opportunities in primary care medical specialities in Oklahoma has significantly increased the number of residency positions. It is hoped that these programs will continue to provide a means of enhancing both the quality and distribution of health care throughout Oklahoma. □

REFERENCES

1. A Study of Oklahoma's Needs in Selected Health Manpower Fields. Oklahoma State Regents for Higher Education, April, 1971.
2. Oklahoma Health Manpower Needs, 1973-74. Division of Research, Planning and Evaluation, Oklahoma State Department of Vocational-Technical Education, 1973.
3. Oklahoma Health Manpower, 1975-80. Division of Research, Planning and Evaluation, Oklahoma State Department of Vocational-Technical Education, 1975.
4. Directory of Approved Internships and Residencies, 1973-74. American Medical Association, 1973.
5. Enrolled Senate Bill 534, Oklahoma State Legislature, 1976.

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Oklahoma's Amended Immunization Law

On January 1st, 1977, all of Oklahoma's public, private, and parochial schools and their student bodies, numbering more than 600,000 children in grades kindergarten through twelve, are required to be in full compliance with the immunization law or be suspended from school until the requirements to the immunization law are met. The immunization law requires that every student attending school in Oklahoma show proof of having received no less than 3 DPT or DT, 4 Polio (TOPV), 1 Rubeola, and 1 Rubella immunization, be in the process of completing these required immunizations, or meet the exemptions for medical, religious, or parental objections within 120 days of school entry.

The Oklahoma State Department of Health has provided all school administrators with complete instructions and necessary forms to fully implement the immunization law in their respective schools. It is estimated that approximately 85% of the state's school population is either in compliance, or in the process of receiving the basic immunizations. Only a small percentage of Oklahoma students should fall into the exemption category for medical, religious, or parental objections. Historically, school immunization surveys have indicated that less than one per cent of the student population seek exemption to the required immunizations.

Physicians should expect an increased demand for immunizations during the next six (6) weeks, as the 120-day grace period is coming to a close. It is recommended that routine immunization schedules be followed in administering required immunizations, and that professional judgment be utilized with those individuals who received only partial immunization earlier in life.

The intent of the immunization law is to protect Oklahoma's school-age children against the preventable childhood disease of measles, rubella, polio, diptheria, pertussis, and tetanus through active immunizations. . . . □

News From The Oklahoma State Department of Health

COMMUNICABLE DISEASES IN OKLAHOMA FOR OCTOBER, 1976

DISEASE	October 1976	October 1975	September 1976	Total To Date 1976	1975
Amebiasis	1	5	3	12	30
Brucellosis	—	—	—	7	3
Chickenpox	38	75	13	1616	1084
Encephalitis, Infectious	2	9	1	17	55
Gonorrhea (Use Form ODH-228)	1126	1239	1287	11168	11068
Hepatitis, A, B, Unspecified	93	52	61	1116	706
Leptospirosis	—	—	—	1	—
Malaria	1	—	—	3	2
Meningococcal Infections	—	1	2	21	10
Meningitis, Aseptic	12	12	—	30	76
Mumps	47	20	18	733	236
Rabies in Animals	24	9	20	145	98
Rheumatic Fever	2	1	—	13	8
Rocky Mountain Spotted Fever	5	2	9	94	88
Rubella	3	3	7	70	89
Rubella, Congenital Syndrome	—	—	—	—	1
Rubeola	5	12	2	295	145
Salmonellosis	22	39	32	219	227
Shigellosis	5	12	11	168	284
Syphilis, Infectious (Use Form ODH-228)	5	15	7	89	80
Tetanus	—	—	—	—	—
Tuberculosis, New Active	55	19	34	325	261
Tularemia	—	—	—	7	9
Typhoid Fever	—	1	—	1	1
Whooping Cough	1	1	1	20	25

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OSMA Executive Director Named



David Bickham, OSMA Executive Director.

David Bickham, an eight-year executive on the OSMA staff, has been named executive director of the state medical association, effective November 1st. The announcement was made recently by the OSMA Executive Committee and came after a month-long search.

Bickham came to the OSMA in 1968 as an associate executive director in charge of legislative affairs. He had served in that capacity since that time. He is also vice-chairman of the Oklahoma Council for Health Careers, Chairman of the Edmond Recreation and Park Board, and served on Governor David L. Boren's Workmen's Compensation Study Commission. He received an OSMA award for distinguished service last year for his work on SB 622, the association's successful malpractice bill.

Bickham came to Oklahoma from Louisiana in 1964. He attended Louisiana State University and Central State University in Edmond. Before accepting a position with the OSMA eight years ago, he had been in the real estate, mortgage and banking business.

An Edmond resident, Bickham is married to Kay Bickham and has two sons, Brad, 14, and Steve, 11.

Bickham replaces Don Blair who served as executive director of the OSMA for 17 years and who had been with the OSMA for 21 years. Blair resigned as executive director on September 6th to accept an executive position with C. L. Frates and Co., the OSMA malpractice insurance counselors. He has now assumed that position and is working on the insurance programs of the OSMA, the Oklahoma Hospital Association and the Oklahoma Osteopathic Association. □

OSMA President Calls for Closer Medical Liasion

Saying the goals and interests of the medical profession and the hospital industry are "intertwined," the president of the Oklahoma State Medical Association has called for closer ties between the state's hospitals, the hospital association and the OSMA. The call for increased cooperation came at the 57th annual convention of the Oklahoma Hospital Association held recently in Oklahoma City.

Orange M. Welborn, MD, OSMA President, told a group of hospital administrators and other officials that, "What affects one group affects the other." He said although liasion between the two organizations has historically been good, more formal mechanisms need to be established.

For example, said Welborn, the professional liability of hospitals and doctors is undeniably "intertwined." He said malpractice lawsuits are rarely brought against a hospital when a doctor is not also involved and that the reverse is just as true. He said mechanisms exist within both organizations which could ease some of the professional liability problems, but an information sharing system should be formally established to make them even more effective.

Welborn pointed out that the OSMA and the OHA had cooperated in passing SB 622 in the Oklahoma Legislature last year. That bill, he said, gives the Board of Medical Examiners the information it needs to act and a recent opinion by the Oklahoma Attorney General gives it the power.

Welborn explained the Board had asked for the opinion to clarify its powers and the action it could take in light of legal reform provided

by SB 622. He said the opinion gives the Board much broader powers and that all that is needed now is a better system of sharing information.

In some cases, said Welborn, we have failed to deal effectively with impaired or troubled physicians because our information mechanisms have broken down. He said the review systems of the OSMA and the individual hospitals often work independently of each other. He said hospital staffs could help by informing the Board of their actions and by informing the insurance committee of the OSMA.

At least that way, he said, we would all have a better idea of what disciplinary steps were being taken at the various levels.

Another avenue which should be explored, said Welborn, is a means of modifying a physician's license. He said the Board of Medical Examiners has statutory power to only revoke or suspend.

The OSMA president suggested that the Board be given the third option of modifying a license to disallow surgery or to otherwise limit the scope of practice. Through this option, said Welborn, we could allow a physician to continue to practice in the areas he is competent, and we could selectively exclude those areas that are questionable.

This is one way of working together to ultimately provide better patient care, he said.

Two years ago, continued Welborn, both the physicians in this state and the hospitals were confronted by unreasonable utilization review regulations which would have placed extreme hardships on us both. Today, as a result of our joint efforts, he said, Oklahoma has a utilization review mechanism unlike that of any other state.

Welborn said when the original utilization review regulations were handed down by HEW in November, 1974, we immediately recognized that many of our smaller hospitals simply would not be able to comply with them. But, he said, we really didn't know what to do about them. As a result of conversations between officials of the OHA and the medical association, we decided to visit Washington, D.C., and seek revisions.

He said HEW initially indicated that it was unwilling to change its regulations to accommodate a state as small as Oklahoma, but later said it would be willing to accept an alternate plan if it were superior to that which HEW had devised.

"At that point," said Welborn, "the medical association, the hospital association and several other interested groups went to work on what is now known as the Oklahoma Utilization Review System," a system which he said is far superior to that being used in any other state.

Welborn said OURS is based on rewarding hospitals which already have good, sound utilization review procedures and auditing more closely those which do not. An analogy, he said, would be the method of examining or auditing the banking business.

"Can you imagine," asked the Ada physician, "the federal government attempting to look over every loan officer's shoulder and review every money transaction to make sure the loan was justified?" It would be impossible, he said, and it's not necessary. What they are interested in, said Welborn, is to make sure each bank has a sound accounting system.

If the bank uses sound systems, said Welborn, there is no need to require an item-by-item, concurrent review.

The OSMA president said the basics of that type of system are included in the OURS plan.

Under the OURS plan, said Welborn, there will be three classes of hospitals . . . fully waived, conditionally waived, and non-waived. The waived hospitals will be those which we know are practicing good, sound business or administrative principles. They will be retrospectively audited each quarter and as long as they continue to practice sound administrative policy, he said, they will be left alone.

Hospitals which show aberrant practices in one or more areas will be placed in a conditionally-waived status, he said, and notified about their problem area(s). If, during the next quarter, he said, the hospital corrects its problems, it will be placed back in the waived status.

Welborn said the main difference between the waived category and the conditionally waived category would be the closeness of inspection and monthly reviews as opposed to quarterly reviews for fully-waived hospitals.

Hospitals which have problems of one type or another which they have not been able to correct will be placed in a non-waived category, he said. These hospitals will have to conduct concurrent reviews in which each hospital admission will have to be justified and approved

by another physician. The review system for non-waived hospitals, said Welborn, will be much more involved and will require a considerable amount of a physician's time.

Welborn said there were many differences between the review system in Oklahoma and that being used in the other states. Colorado has about as many physicians as Oklahoma, said Welborn, and their utilization review-PSRO (Professional Standards Review System) costs about $2.5 million each year. He said the Oklahoma system would cost only about $250,000.

"That's a considerable sum of money we are saving the taxpayer," he stressed.

The OSMA president said the OURS plan was envisioned in an effort to make utilization review effective and meaningful without imposing a hardship on a hospital or its staff.

"If a hospital is already functioning well, there is no reason to require it to do something different and more difficult."

The plan we were able to write for this state, he said, is another example of how cooperation between the hospital association and the medical association has helped provide better health care delivery. □

OSMA-OFPR to Share Building

The OSMA Board of Trustees has approved a plan to remodel OSMA headquarters and rent space to the Oklahoma Foundation for Peer Review. According to the plan, the OFPR's staff, which is soon expected to reach seven persons, will be housed in the OSMA's building at 601 NW Expressway in Oklahoma City.

The plan approved by the Board authorizes the remodeling and the renting of space to the OFPR for approximately one year. After one year the OFPR is expected to move since by that time the staff will probably grow too large for the space that is available.

A major reason for the move is Ed Kelsay's new association as a consultant to the OSMA. Kelsay is now dividing his time between the OFPR and the OSMA. He had been an associate executive director of the OSMA for eight years before he accepted a position with the OFPR approximately a year ago. □



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Delegates Vote Unified Membership

The OSMA's House of Delegates and Board of Trustees have reaffirmed the association's long-standing unified membership with the AMA by voting 65-26 to require that all OSMA members belong to the national organization. The vote at the October 24th meeting reversed a decision reached at the last annual meeting which would have made AMA membership voluntary.

Prior to the April annual meeting, the OSMA had unified membership for nearly 27 years — since the AMA first charged dues in 1950. Oklahoma is the only state which has never dropped the AMA membership requirement during that period and is one of six states which now require it. A resolution passed last April, however, would have made membership in the AMA voluntary, although physicians belonging to the state association would still have been required to pay a sum equal to AMA dues ($250).

Under that plan, if an OSMA member chose not to belong to the national association, the $250 would have been "equitably" divided between the local county medical society and the OSMA according to a schedule developed by the Board of Trustees.

When the Board reviewed the House-approved plan at its July meeting, however, it discovered serious procedural and constitutional questions. The plan was eventually ruled constitutional, but the procedural questions were never resolved.

The Trustees pointed out that the OSMA Bylaws required that all amendments to the Bylaws be introduced in writing at the opening session of the House of Delegates. This requirement, they said, was not met since the Tulsa County resolution for voluntary membership was amended at the closing session and in a manner which required more amendments than were cited in the original resolution.

Additionally, the Trustees felt that the amended resolution was potentially divisive. Sitting as the OSMA's judicial council, the Board of Trustees decided to call the House of Delegates back into session "in the interest of unity."

Once the House reconvened, the question of unified vs. voluntary AMA membership and the procedural problems surrounding the action taken in April were quickly resolved. Declining to further debate an issue which had been considered at the last four annual meetings, the House chose to vote directly on a motion from a Tulsa County delegate to make AMA membership strictly voluntary. The motion was defeated 65-26, thus reaffirming the House of Delegates' desire for unified membership.

In order to bring this about, the Board of Trustees met immediately afterward. Board Chairman, James B. Eskridge, III, MD, entertained a motion to rescend the action taken in April and the motion passed unanimously.

As a result, the Bylaws concerning the AMA membership are unchanged and Oklahoma is still a unified state. As in the past, OSMA members must also be members of their county society and the AMA. □

Physician Requests Information

S. E. Hyler, MD, is interested in corresponding with any other physician who has had experience in treating patients with Munchausen Syndrome (Hospital Addiction). He is currently engaged in research of this syndrome. All responses should be addressed to: H. E. Hyler, MD, 5620 Netherland Avenue, Riverdale, New York 10471. □

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State Insurance Outlook Bright

While doctors in many states face skyrocketing insurance premiums or the grim prospects of going "bare," doctors in Oklahoma are assured of a stable and reasonable insurance program at least through 1977.

Oklahoma doctors have enjoyed one of the most successful professional liability programs for many years, and 1977 will be no different. When insurance premiums become due on January 1st, physicians in this state will again be paying what are probably the lowest premiums in the country . . . due mainly to the work of the OSMA Council on Members Services, the OSMA staff and the insurance counselors at C. L. Frates and Co.

Last year when the malpractice insurance problems threatened to reach crisis proportions throughout the country (including Oklahoma), physicians here experienced a 50 per cent increase for the basic coverage and an unprecedented increase of between 100-200 per cent for the umbrella coverage. That still left Oklahoma premiums lower than those in any other state, but the prospects for 1977 were less than encouraging.

As a result, the OSMA went to the Oklahoma Legislature, passed malpractice reform, and now the insurance market in this state again appears stable. How much of the stability is a direct result of the malpractice reform offered by SB 622 no one knows, but what is known is that insurance coverage will cost only about 20 per cent more next year.

As in the past, the Insurance Company of North America will be the insuror for the basic $100,000/$300,000 policy. The net increase for insurance through INA will next year be only 15 per cent . . . small when compared to what has happened in most other states. To keep the increase that small, however, the OSMA had to renegotiate its terms with INA.

First of all, the one-year old stabilization fund is now gone, and Oklahoma doctors will not be required to pay into it in 1977. The fund was established last year as an inducement to INA to continue writing malpractice insurance and in lieu of a major premium increase. Both INA and the OSMA feel it is no longer necessary, and it has now been phased out. The cost of this fund was 15 per cent of the previous year's premium for the basic insurance, and phasing out the fund has helped hold down the rate increase for 1977.

Although the insurance itself will cost 27 per cent more next year in each category, by subtracting the stabilization fee, physicians will really pay only 14 per cent more. A category by category comparison of last year's rates and those for the basic coverage in 1977 is shown below.

In order to hold down the cost of the "umbrella" or excess limits coverage, the OSMA has renegotiated that contract with a different company. Continental National American, the company which has written this policy for the last few years, received a rate increase of between 100-200 per cent last year and asked for an increase in that vicinity plus a "claims-made" policy for 1977. The OSMA felt CNA's requests were unreasonable and decided to "shop" the plan around with other companies.

As a result, the OSMA will soon enter into a contract with Lloyd's of London. The contract will be for "excess limits," but the provisions of the contract will allow the OSMA to hold down the cost of the program and assume a portion of the risk.

Under the plan, the OSMA will purchase an aggregate amount of insurance for all physicians in the OSMA of $3.25 million. This sum will apply to only the first $1 million layer of excess, and all losses will be paid from that sum. If the OSMA loss experience worsens materially and we lose more than the $3.25 million through malpractice claims, the OSMA will be responsible for those losses. To date, however, the worst year the association and CNA have experienced was in 1974 when

1977 Net Increase in Cost of INA Primary Policy Limits: $100,000/$300,000

Class Group	(a) 1976 Premium	(b) 1976 Stabilization Fund	Total 1976 Cost (a) + (b)	1977 Premium	$ Increase	% of Increase
CLASS I	$ 273	$ 31	$ 304	$ 347	$ 43	14%
CLASS II	484	59	543	615	72	14%
CLASS III	957	107	1,064	1,215	151	14%
CLASS IV	1,275	142	1,417	1,619	202	14%
CLASS V	1,594	178	1,772	2,024	252	14%

$397,397 in claims were paid. Even with the worsening insurance picture, the OSMA counselors feel the sum offered by Lloyd's is more than adequate.

Oklahoma doctors will receive the Lloyd's certificate with the same coverage as last year for only a 20 per cent increase in premiums . . . again low when compared to the national trend.

Since the Lloyd's policy only includes the risk layer from $100,000 to $1 million, however, the OSMA is negotiating risks from $1 million to $5 million with other insurance companies. □

Hair Transplant Symposium Scheduled

The American Society for Dermatologic Surgery and the American Academy of Facial Plastic and Reconstructive Surgery are cosponsoring the Fourth Annual Hair Transplant Symposium and Workshop on February 11th and 12th, 1977. Site of the meeting will be the Stough Dermatology and Cutaneous Surgery Clinic, P.A., Doctors Park, Hot Springs, Arkansas 71901.

Designed to offer an opportunity for the exchange of ideas among various disciplines, the conference will also present the latest advances in techniques on hair transplantation.

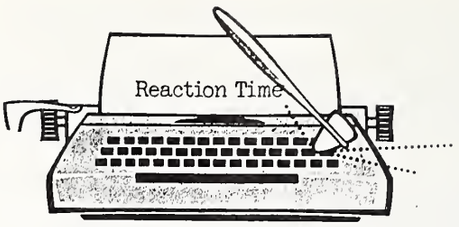
The multi-discipline, international faculty will include dermatologists, otolaryngologists, regional and general plastic surgeons.

Attendance will be limited. Interested attendees should contact D. B. Stough, III, MD, Program Director at the above address. □

Lupus Association Receiving Applications for Grant

The Oklahoma Lupus Association, Inc., a chapter of the Lupus Foundation of America, is taking applications for a $5,000 grant for lupus research. The research group was raised in 1976 through association-sponsored activities, donations and memorial contributions. The grant is to be used for research only.

Requests for the grant should be submitted to the Oklahoma Lupus Association, 3848 N.W. 31st Street, Oklahoma City, Oklahoma 73112, no later than January 1st, 1977. All requests should include a complete description of the specific research contemplated, as well as any that is in progress. □



Mark R. Johnson, M.D.
Editor-in-Chief
The Journal of the Oklahoma
State Medical Association
601 N.W. Expressway
Oklahoma City, Oklahoma 73118

Dear Doctor Johnson:

In the July 1976 issue of the Journal in the article entitled, "The Well-Baby Visit," there are some statements which are so in error that we feel that a letter of correction is necessary. The Early Periodic Screening, Diagnosis and Treatment program is mandated by Federal law and regulations. The caseworkers do work with the recipients in order that the Department may stay in compliance and continue to receive Federal matching funds. It is possible that patients may not understand why they need to see the physician. However, I think frequently patients after seeing the physician for acute care do not know why they saw him or what the physician intended them to do. I feel that there are problems of communication in all areas. It is true that the Department does not pay for routine well-child care but the early screening program is not a routine well-child program. This program was designed to detect remedial defects at the earliest possible time and to correct such defects. Payment for these services is not made to organized out-patient clinics. Payment is made only to private physicians who do the screening. The attempt is to institute longitudinal care in every instance where it is available. Therefore, many of the statements made concerning screening are invalid. Further, when the private physician makes a referral, if it is found that an appointment has not been made, the worker attempts to help the patient get an appointment with an appropriate physician for care. These are followed up and referral is instituted within sixty days of the time that the recommendation is received in the State Office. Inci-

dentally, the Department experimented with various forms prior to the adoption of this one. The Department included only those things which were stated as specific in the guidelines and left the options for other studies to the individual physician in whom we have enough confidence to do an adequate examination appropriate for the patient's age and any potential problems this patient may have. It is true that many of the physicians who are seeing children on a longitudinal basis as they have for years for recipients of this Department fail to see the need for completing the form. We are in agreement with this opinion and have so written the Department of Health, Education and Welfare, however, the regulations as published still stand.

Very truly yours,
L. E. Rader, Director of Institutions,
Social and Rehabilitative Services

This letter prepared by Stephen R. Ryter, MD, is in response to the letter of August 4, 1976, from Mr. L. E. Rader concerning the article entitled "The Well-Baby Visit" which appeared in The Journal **69**:*314, July 1976.*

I appreciate Mr. Rader's defense of his Department and its role in carrying out the EPSDT program in Oklahoma. I, personally, have participated in the completion of EPSDT examinations in both organized outpatient clinics in Oklahoma City (without payment) and in my office (with payment) and thus feel qualified to comment on the program from the viewpoint of one practicing pediatrician.

My comments which provoked Mr. Rader's letter were made at a time when EPSDT was in its early infancy and was more chaotic than is now the case. Yet, this program has still not fulfilled its potential for a variety of reasons, even now. Among these is the fact that too much stress has had to be placed upon compliance with federal guidelines in terms of numbers of children screened in order that matching funds not be withheld from the states. This potential loss of money has served as the major impetus behind the actual implementation of EPSDT since its inception.

I cannot dispute Mr. Rader's claim that longitudinal care for children found to need follow up is now being accomplished. In actual practice, completion of the EPSDT form by the majority of those involved in screening examinations is too often viewed as an end in itself. Continuous care is the more proper goal, obviously, and the EPSDT form should only be a means of achieving this.

Federal guidelines permit each state to develop its own program. Since my remarks were made in a discussion of the "Well-Baby Visit" I felt it important to point out that EPSDT in Oklahoma does not serve to provide the guidance and counselling necessary for parents with very young children. Rather, it mandates yearly visits through the 21st birthday. Multiple "Well-Child" visits in the first year might well prevent dental caries, child abuse, failure to thrive, and other diseases which have their inception in early infancy. I consider this preferable to the detection of these "defects" later in life. I could include the subject of immunizations here, but that would require more space than is available.

Specific age-defined guidelines for items to be screened may not be necessary for most practitioners. I believe, however, that emphasis upon problems most often encountered at certain ages is appropriate. A specific age-related form would probably reduce expenditures for laboratory tests and make the examinations themselves more meaningful.

Aside from my comment concerning longitudinal care, which was valid at the time of the Grand Rounds, my views have only been strengthened since then by personal experience. I would rather the energy involved in Mr. Rader's defense of this unwieldy, ill-conceived, although well-intentioned program had been directed towards making Oklahoma's EPSDT effort more prevention-oriented and, therefore, more meaningful for our children and their parents. Perhaps this interchange of letters will serve to stimulate a purposeful dialogue.

Stephen R. Ryter, MD
Clinical Assistant Professor of Pediatrics □

Book Review

THE FUTURE OF PHILANTHROPIC FOUNDATIONS, Ciba Foundation Symposium 30 (new series) held jointly with the Josiah Macy Jr. Foundation, 240 pp, Elsevier-Medica-North Holland, Associated Scientific Publishers, Amsterdam. Oxford, New York, 1975, Price not given.

The Ciba Foundation and the Josiah Macy Jr. Foundation joined together to hold a Ciba Foundation Symposium during the summer of 1974 on the future of philanthropic foundations.

As pointed out, foundations are under fire

from many directions. Their assets have decreased in value and governments are undermining their independence. Against this background, the Ciba Foundation marked its 25th anniversary by holding a meeting on problems common to foundations, universities, and similar institutions from all parts of the world. The formal and informal contributions of leaders from such organizations form the substance of the Ciba Foundation Symposium 30.

This monograph provides an unusual overview into the activities of foundations and emphasizes the differences existing among foundations in different parts of the world as well as among those of different sizes. It is of particular interest to American leaders in view of the recent Federal Commission reports which are focused on philanthropy.

The presentation and discussions address problems common to the foundation movement, universities and other educational institutions and to grantees who receive support from foundations.

This book will be of interest particularly to university administrators, government officials and those associated with foundations. However, there is much material of interest to all persons associated with higher education.
Harris D. Riley, Jr., MD □

Miscellaneous Advertisements

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(E)—Editorial
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(D)—Deaths
(Pic)—Picture
(GN)—General News
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Cardiology Symposium Set for January

A symposium designed to investigate the medical aspects of coronary disease will be held January 14th and 15th at the Hilton Inn in Tulsa. The symposium, entitled "Coronary Disease 1977," will be cosponsored by the John Steele Zink Medical Institute and Hillcrest Medical Center.

The symposium will combine formal lectures by three well-known guest speakers with problem oriented case presentations by practicing physicians. The two-day program is approved for seven hours of Category One credit by the American Medical Association and seven hours of Prescribed Credit by the American Academy of Family Physicians.

Guest speakers will be H. J. C. Swan, MD, PhD, Director of Cardiology, Cedars-Sinai Medical Center, Los Angeles; W. Dudley Johnson, MD, Associate Clinical Professor of Surgery, Department of Thoracic-Cardiovascular Surgery, Medical College of Wisconsin, Milwaukee; and Robert J. Hall, MD, Medical Director of the Texas Heart Institute, Houston.

Persons interested in attending should write Cardiology Symposium, Hillcrest Medical Center, 1120 S. Utica, Tulsa, Oklahoma, 74104 or call (918) 584-1351, Ext. 388. □

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Let's Bring Back Safety On The Street, Seminar for Women

The Assault-Oriented Safety on the Street Seminar held in Grady County earlier this year is a good example of how an auxiliary can cooperate and join forces with other organizations in the community to carry out a worthwhile project for the area. Through this program the women of Grady County were told common sense precautions they could take as they go about their daily routine. They stressed women can protect themselves and their loved ones by being aware, sharing facts and knowing what to do. Women do not want to live in an atmosphere of fear — fear of going out alone, fear of staying home alone, fear of break-in, purse snatching and other robberies. As a member of an organization or community group she can help initiate action. The Woman's Department, National Safety Council, has the material and guidelines for getting started on a safety program planned by and for women or any other area of concern that might be a safety problem in your community.

The Auxiliary to the Grady County Medical Society received a national award for this program. They received one of the 12 second place Awards of Merit from the Woman's Department of the National Safety Council when they met in Chicago October 16th-19th. Betty Wilkinson, Immediate Past-President of the Auxiliary to the American Medical Association and Award Chairman for the Woman's National Safety Council presented an Award of Merit plaque during the awards ceremony.

This national award winning program grew out of a concern of the safety committee of the auxiliary, who felt there might be a need for a safety program planned especially for women. Through personal contact and questionnaires an attempt was made to find out women's greatest concerns. The response indicated a need for an informative assault-oriented safety program. They discussed the National Call for a Woman's Crusade for Safety on the Street by the Woman's Department of the NSC and urged the entire membership of 26 women to join in answering that call. They received the approval and support of the Grady County Medical Society.

The first step was to find other organizations in the county who shared their concern. The Grady County Home Makers Extension Council and the Federation of Women's Clubs were eager to assist. Representatives from these two organizations joined the auxiliary in forming a committee to plan a half-day seminar. Materials and guidelines suggested in the pamphlet "Let's Bring Back Safety on the Streets" from the Woman's Department of the NSC were used. Trooper Bill Brothers, Safety Education Division of the Oklahoma Highway Patrol, Lawton Division, served as the program leader. The seminar included a talk by Trooper Brothers, safety demonstrations, a film — "It Could Happen To You" and a question and answer session. Each person had an opportunity to express her fears and work through them. One person expressed the feelings of many of us when she said: "I do not feel so helpless now. There are many common sense precautions I can take that I had never thought of before."

Our thanks to the town mayors in Grady County who signed proclamations declaring a Safety On The Street Week, the newspapers who gave good publicity and the local radio station who gave spot announcements of our program. Also to the committee members who made posters and placed them in store windows throughout the county.

It is too early to determine the overall results achieved from this program. During the evaluation session the committee agreed this program is only the first step we must take if we are to help our county become a better and safer place to live. *Jewell Coates (Mrs. R. R.) Grady County Safety Chairman – Auxiliary to the Grady County Medical Society.* □

A recent opinion by Oklahoma Attorney General Larry Derryberry and Assistant Attorney General David K. McCurdy has given the Oklahoma Board of Medical Examiners broader powers in dealing with the professions licensed by that group. Presently, the Board licenses medical doctors, physician assistants and physical therapists. The opinion was requested by the Board's Secretary, Ed Young, MD, El Reno, in response to a section of SB 622 which directs professional liability insurance companies to provide the Board an itemized account of malpractice lawsuits and their disposition. In effect, the opinion states that the Board may revoke or suspend a license "for unprofessional conduct," but broadens its interpretation. The opinion states that unprofessional conduct as defined in Title 59, Section 509, 1975 Supplement, "is not confined to the acts specifically enumerated." It is apparent, said the opinion, that the Board, subject to the provisions regarding notice, process, hearings, rulings and record of proceedings, could prescribe "unprofessional conduct" to include incompetence and/or negligence as grounds for suspension or revocation. Neither incompetence nor negligence is specifically listed in the statutes as constituting unprofessional conduct.

The OSMA will again seek changes in Oklahoma's workmen's compensation laws, although the mechanisms through which the changes will be attempted has not been decided. David Bickham, OSMA executive director, made those comments in a recent interview with *The Daily Oklahoman*. Bickham said the association favors a change to an impairment system of determining a worker's injury rather than the present disability system. He said doctors are presently asked to determine the degree of disability and then to relate disability to earning capacity. "That is as much sociological and economic as it is scientific," said Bickham. We favor removing the physician from the situation where he has to make a decision on how much income his patient will receive. Bickham also urged adoption of a medical panel from which an impartial physician could be selected when the degree of impairment differed by more than 20 per cent. Bickham said if the governor's workmen's compensation package gets bogged down in the legislature, the OSMA will probably try to push forward with its own bill.

A total of 57,236 medical students were enrolled in 116 medical schools across the country this fall, including 15,349 first-year students — a record number, the American Medical Association reported recently. The rate of increase of enrollment tapered off this fall, increasing only slightly over last year. The nation's medical school enrollments are leveling off, at least temporarily, the AMA said. Total enrollment this fall is about 9.7 per cent greater than last year's; the first-year enrollment is about 9.4 per cent greater than last year. Women students accounted for 20.4 per cent of total enrollment in the medical schools this year, about the same percentage as last year. Minority students represented 8.2 per cent of total enrollment, and 9.3 per cent of the freshman class, about the same as last year.

The latest edition of the OSMA MEDICAL DIRECTORY is hot off the press and has been mailed to every practicing medical doctor in the state of Oklahoma. The new 156-page publication contains over 3,000 telephone and address listings of medical doctors in Oklahoma, plus other pertinent information such as medical school, specialty or special interest, and year of graduation. Also included in the Directory is a listing of doctors by city of practice, a listing of Oklahoma's hospitals and a listing of frequently called telephone numbers. This Directory is a special project of the OSMA and one complimentary copy is provided free of charge; medical doctors may purchase additional copies at the special price of $5. The price for all others is $10. To order additional copies or in the event you did not receive your complimentary copy, write: OSMA Medical Directory, Oklahoma State Medical Association, 601 NW Expressway, Oklahoma City, Oklahoma 73118. □

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